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ABSTRACT

The Pride in Parenting (PIP) program was developed for mothers 18 years of age or older who had little or no prenatal care and their infants from birth to one year. The major goals of the program were to promote effective use of health services by mothers and their infants and to enhance infant development. The intervention program consisted of home visiting, a parent-infant developmental playgroup, and a parent support group designed to improve parenting skills and maternal social competence. This training model and curriculum from the program create a comprehensive instruction course to prepare lay home visitors for facilitating healthy changes in behaviors of high risk mothers. The training curriculum is designed for a 45-day intensive training program over a 9-week period. Following an introduction to the training, the curriculum units for home visitors (parent support specialists) cover: (1) communication and relationship-building skills; (2) coping with stress and problem solving and decision making; (3) helping clients build self-esteem and deal with feelings; (4) using curriculum support materials; (5) working with families; (6) cultural diversity/ethnicity among families; (7) postpartum care and planning; (8) family planning options; (9) infant feeding and nutrition; (10) health care in the first year; (11) child growth and development; (12) identifying family needs and accessing community resources; (13) managing home visits; (14) child growth and development--birth to 1 month; (15) 1 to 4 months; (16) 4 to 8 months; (17) 8 to 12 months; (18) 1 to 2 years; (19) children in violent circumstances; (20) behavior and discipline; (21) health promotion for families; (22) maintaining personal safety; (23) substance abuse; and (24) evaluation and closing ceremony. A questionnaire to ascertain trainees' knowledge of important training concepts is included in the first unit. (HTH)

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PRIDE IN PARENTING

TRAINING CURRICULUM FOR LAY HOME VISITORS

NIH-DC INITIATIVE TO REDUCE INFANT MORTALITY IN MINORITY POPULATIONS

Linda T. Diamond, M.S. and Marion H. Jarrett, Ed.D., editors.

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PRIDE IN PARENTING
Training Curriculum for Lay Home Visitors

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PRIDE IN PARENTING
TRAINING CURRICULUM FOR LAY HOME VISITORS
INTRODUCTION

Program

The training of home visitors is a vital component of any successful community-based outreach program, especially those programs focused on high risk mothers and their babies. The training model and curriculum presented in this manual create a comprehensive instruction program to prepare lay home visitors for their most important task - facilitating healthy changes in behaviors of high risk mothers.

Pride in Parenting (PIP) has been a funded project of the NIH-DC Initiative to Reduce Infant Mortality in Minority Populations, a research program mandated by the U.S. Congress in 1992 to address issues of infant mortality in Washington, D.C. Mothers 18 years of age or older who had little or no prenatal care and their infants from birth to one year were the focus of the PIP program. The major goals of the program were to promote effective utilization of health services by mothers for themselves and their infants and to enhance infant development. The intervention program consisted of home visiting, a parent-infant developmental playgroup, and a parent support group designed to improve parenting skills and maternal social competence.

Training

The PIP Training Curriculum for Lay Home Visitors, ensured that the PIP Parenting Support Specialists (home visitors) were adequately prepared to deliver the home visiting curriculum. The content of the training was determined by the overall goals and objectives of the research project and was designed to enable trainees to achieve competence in the following areas:

1. Interpersonal communication skills including active listening and non-judgmental communication style
2. Teaching strategies for effective delivery of health and parenting information
3. Health care needs and health services utilization for mothers and infants
4. Stressors impacting low income, minority families
5. Problem-solving strategies that respond to common family situations
6. Infant care and development in the first year
7. Developmental programming for infants
8. Community resources for mothers, infants, and families
9. Program documentation and evaluation

The training program was developed and delivered by members of the Pride in Parenting research team which included early interventions, psychologists, nurses, public health personnel, physicians, and research specialists. The diversity of professional backgrounds of the training program authors is evident in the different styles reflected in the various units. Each unit follows a similar format, but is designed to allow for expansion and enhancement of the training through the knowledge and experience of individual trainers. This feature of the training enables trainers to modify the material/training to accommodate the needs of a specific program or population.

Training Model and Format

The Pride in Parenting Training Curriculum for Lay Home Visitors was designed to be used in a 45 day intensive training program over a 9 week period. This training schedule can be adapted to address the needs of trainees with nursing, education or other professional backgrounds. For example, single units can be used for one-day workshops or several related units can be organized into one-week training sessions.

The curriculum is divided into 25 units, each focusing on a different subject. A brief Introduction is provided as well as a list of Learning Objectives to be addressed in the unit. An outline with approximate times for teaching each unit is included. These assist the trainer in maintaining the flow of information and activities during each training session. Materials and Advance Preparation sections include information about what needs to be done prior to training. Trainer's Notes provide guidelines for the training content, as well as the presentation of materials. Trainee participation and skill practice are emphasized throughout the PIP Training Curriculum.

Training Evaluation

Evaluation of the PIP Training Curriculum was conducted throughout the training and at its conclusion. Evaluation for program improvement and quality assurance required continuous evaluation to provide data for revision of the training program at any time it was needed. At the end of each unit, the training facilitator tested knowledge gained by rephrasing unit objectives into questions. For example, from a child development unit, the objective is "to list possible developmental problems to which the PSS should be alert during this stage". One of the questions asked at the end of training for that unit would be "What are the red flag behaviors to watch for at one year of age?" Questions answered incorrectly guided the training facilitator in clarifying information, designing individualized instruction, and making necessary changes to the curriculum. Post-unit Evaluations sought trainees' perception of the unit: Was all information covered as stated in the objectives? Was the information presented clearly? These evaluations are included at the end of each unit of this manual.

Additional opportunities for trainees to assess and guide the training content and process were provided by suggestions solicited by the training facilitator and through individual meetings with the PIP project director at regular intervals throughout the nine-week training. Trainees were comfortable offering constructive criticism to the project director that would then be shared anonymously with the trainers.

Trainees attainment of competencies was evaluated at the end of each unit and again upon completion of the training program. Tests designed by unit trainers were used to assess trainees' achievement of the competencies reflected in the objectives of each unit. These tests are included in each unit. A Pre-test and Post-test Questionnaire, designed to ascertain the trainees' knowledge of important training concepts, was administered at the beginning and end of the 45-day training and was used to compare pre and post-training knowledge on an individual and group basis. The questionnaire is included in Unit 1.

The PIP Training Curriculum is comprehensive in its content and includes many references for trainers to review for additional information. Unlike other intervention programs that emphasize either health or infant development and parenting, the PIP curriculum incorporates both. The training is culturally sensitive, easy to use and can be easily adapted for various populations.

TABLE OF CONTENTS

Unit 1: Introduction to the Training
Unit 2: Communication and Relationship-Building Skills
Unit 3: Coping with Stress: Problem-Solving and Decision-Making
Unit 4: Helping Clients Build Self-Esteem and Deal with Feelings
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Unit 6: Working with Families
Unit 7: Cultural Diversity/Ethnicity Among Families
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Unit 11: Health Care in the First Year
Unit 12: Child Growth and Development: Introduction
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Unit 17: Child Growth and Development: Four to Eight Months
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Unit 19: Child Growth and Development: One to Two Years
Unit 20: Children in Violent Circumstances
Unit 21: Behavior and Discipline
Unit 22: Health Promotion for Families
Unit 23: Maintaining Personal Safety
Unit 24: Substance Abuse
Unit 25: Evaluation and Closing Ceremony

Unit 1
INTRODUCTION TO THE TRAINING

[illegible] session, trainers and Parenting Support Specialists (PSS) introduce themselves and set both personal and program goals and objectives.

Objectives

By the end of this unit, participants will be able to:

- Express their feelings and concerns about being a PSS.
- Discuss their personal learning objectives and training they feel is needed to become a PSS.
- Discuss the goals and objectives of this training course.
- Define the value of a PSS.
- Describe the characteristics/qualities of an effective PSS and discuss their own strengths that will help them become an effective PSS.
- Discuss at least three of the various tasks and activities carried out by a PSS.
- Explain the goals of the PIP Project.
- Explain the roles of the project staff.
- Describe appropriate interaction with project staff and families to include:
  - * obeying workplace policy rules
  - * polite interactions with co-workers
  - * telephone courtesy
- Explain the importance of team building; discuss strategies to develop and maintain team support.

Time

2 days

Outline

A. Introductions: Ice Breaker Exercises
B. Information About the Pride in Parenting (PIP) Project
C. Reception for Research Team and PSSs to Meet
D. Overview of Training Program/Schedule
E. Team and Skill Building I
F. Value of Parenting Support Specialists
G. Goal Setting
H. Additional Team Building Exercises
I. Qualities and/or Characteristics of an Effective PSS
J. Activities/Tasks That May Be Expected of a PSS
K. Team and Skill Building II
L. Summary and Review

Adapted with permission from Resource Mothers, 1993.

Materials

- Resource Mothers. (1993). Resource Mothers Handbook (Ch. 1). Sterling, VA: INMED.
- Newstrom, J.W. [illegible]ell, E.E. (19[illegible]). Games Trainers Play, (pp. 95, 127, 131, 195, 205). NY: McGraw Hill, Inc.
- Obtain copies of ***101 Things You Can Do To Put Children First***

  Coalition for America's Children
  1634 Eye Street N.W. 12th floor
  Washington, D.C. 20006
- Pre-Test Questionnaire **(Handout #1)**
- Introductions: Ice Breaker Exercise **(Training Aid #1)**
- Agenda for First Day **(Training Aid/Handout #2)**
- Distribute a roster of people involved with PIP (sample not included)
- Organization Chart **(Training Aid/Handout #3)**
- Overview--The Pride in Parenting Program **(Training Aid/Handout #4)**
- Primary Goal and Program Objectives **(Training Aid/Handout #5)**
- Primary Activities **(Training Aid/Handout #6)**
- Primary Outcomes **(Training Aid/Handout #7)**
- Training Schedule for Parenting Support Specialists [PSS] **(Handout #8)**
- Outreach Worker/PSS **(Handout #9)**
- Post-Unit Evaluation
- Easel, newsprint, markers, tape, blackboard and chalk.

Advance Preparation:

- Review Ice Breakers suggested or decide on Ice Breakers of your choice; collect necessary materials.
- Review the *Resource Mothers Handbook*, Chapter 1 and *PIP Operations Manual.*
- Prepare a training schedule and any handouts and overheads needed.
- Make sufficient copies of any handouts to be used during the session.

A. INTRODUCTIONS: ICE BREAKER EXERCISES (1 hour)

Rationale: You and the Parenting Support Specialists (PSS) are going to spend a lot of time together during training. "Ice Breaker" exercises are designed to help adult learners feel at ease. This should be done even before you give an overview of the training workshop. All persons who plan to spend time in the training room should participate in this exercise, not just the future PSS. A specific time can be set aside for entire research team and the PSSs to participate in an Ice Breaker together.

Procedure: 1. Begin with the Agenda for the day- **Training Aid/Handout #2**. There are many exercises to use at the start of a training workshop. Three possibilities are outlined in **Training Aid #1.** Or you may have a favorite that has worked well in the past; feel free to substitute your own exercises at any time for those included in this Training Manual.

2. Distribute pre-test (**Handout #1**). Instruct the trainees that they should do their best, but they are not expected to know all answers since they have not yet been trained.

B. INFORMATION ABOUT THE PRIDE IN PARENTING (PIP) PROGRAM (2 hours)

Rationale: Sharing the goals and objectives of PIP will help to clarify expectations and can help promote the sense of shared camaraderie and mission.

Procedure: 1. Begin by explaining that the program is part of a fairly recent "movement" that is gaining momentum all across the United States. Their common thread is training people from within the community to reach out and help others, and to work with people especially parenting women on their "own turf," i.e. in their homes or a similar place of their choosing. So, while this program is a part of something big, the strength of the PIP program, what makes it successful, is each single individual! Handout *101 Things You Can Do To Put Children First.*

2. Have Principal Investigator speak to PSSs about project mission and particularly their role.

3. Review the goals and objectives of the PIP Project. Discuss an organization chart for the program (**Training Aid/Handout #3**).

Goals and objectives, plus planned activities and expected outcomes, will be provided by the Project Director or Intervention Coordinator to give an overview of this specific program (**Training Aid/Handout #4-7**).

4. There are many prenatal and early child programs. Some work well, others do not. Ask participants to focus on why the PIP Project should work so well.

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Ask them to identify and discuss benefits for themselves, as well as for the clients. List the responses as goals and objectives.

5. Be sure to ask for questions or comments before moving on. During the initial stages of the training, it is particularly important that participants feel comfortable with sharing experiences, and making comments.

C. HOLD RECEPTION FOR RESEARCH TEAM AND PSSs TO MEET

Rationale: Team building.

Procedure: Have the research team introduce themselves, their background and their particular interest in this project. Do the Ice Breaker done in the morning- tell one thing about yourself that no one would guess from looking at you. Have PSSs share what they said earlier or share something new. Have refreshments and time for everyone to interact.

D. OVERVIEW OF THE TRAINING PROGRAM/SCHEDULE (45 minutes)

Rationale: An overview of training will assist everyone in feeling comfortable and will guide expectations.

Procedure: 1. Explain what will happen during training. Refer back to the goals and objectives identified by the trainees. Share your objectives for this training workshop. Emphasize the value that the PSSs bring to the training course. You value the skill and experience they bring to the program. Let them know that much of what they learn will be from each other. Identify common program and personal goals.

2. Pass out a schedule (**Handout #8**): It is much easier for participants to follow your explanation if they have an outline in front of them detailing what skills and information will be provided on what days and at what times.

3. Explain that at the beginning of each day you and the PSS's will look at the objectives for a particular unit. [**Note:** it is important to review these together so everyone has a clear understanding of what is expected. Learning objectives will always be included on the first page of each unit. You or a volunteer should put the objectives for a particular unit on newsprint so everyone can refer to them from time to time during that day's training.]

4. Explain that the *Resource Mothers Handbook* will be used by you and by the participants as a major reference material. Training activities will provide participants with an opportunity to discuss information provided in the *Handbook* and provide opportunities to practice communication techniques.

5. Discuss any "housekeeping procedures" including morning and afternoon breaks, lunch time, location of rest rooms, participants' responsibility for [illegible] and reading, times when video cameras will be used (if relevant), use of telephones during breaks, etc. Be sure to ask for questions.

6. Ask for participants' input into the kind of "rules and guidelines" they would like to establish for the training: attendance, punctuality, dress code, seating arrangements, etc. Have someone put agreed-upon decisions on newsprint and tape it where it is visible throughout the training.

7. Discuss workplace interactions.

E. TEAM AND SKILL BUILDING I (½ hour)

Rationale: Team and skill building is extremely important to the project's success and to job satisfaction.

Procedure: Use an Ice Breaker focused on positive feedback, i.e., p.127 in Games Trainers Play. Focus on stressing the importance of positive feedback to the clients.

F. VALUE OF PARENTING SUPPORT SPECIALISTS (2 hours)

Rationale: Personal reflection on what motivates each PSS to become a mentor and advocate for her community will help each to set personal goals. A shared reflection will help the group develop a sense of trust and cohesiveness.

Procedure: 1. Explain to the group that a river is a very meaningful symbol in many cultures, and most people find it easy to use this symbol to reflect on their personal lives. [Note: A road with bridges, tunnels, road blocks can also be used if that seems more relevant to your group.]

2. Demonstrate on the newsprint how to draw a river, tributaries and dams. The tributaries represent important events or changes in life that have contributed to the development of the role of PSS. The dams represent events or changes that slowed down or blocked progress toward the role of community mentor/advocate/PSS.

3. Ask each person to draw her own river of life[1]. Be sure that the trainees understand that they share only those aspects of their lives that they are

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The River of Life Exercise is adapted from Nina Wallerstein and Frances Varela-Gittings, eds. "Community Organizing: An Experience for Building Health in Communities, Department of Family and Community Medicine, University of New Mexico, 1991, and Ann Hope and Sally Timmel, "Training for Transformation" A Handbook for Community Workers, Center of Concern, 1984.

comfortable sharing. They will be asked to meet in small groups to discuss their rivers (or roads). Allow 20-30 minutes for drawing.

4. Ask trainees to form groups of three to share experiences illustrated by the rivers. Allow one hour for sharing. Because of the sensitive nature of this exercise, and particularly since the PSS's don't know each other well yet, it may be best not to share with a large group. Ask if trainees wish to share their rivers by hanging the drawings on the wall for all to share informally.

5. Process this exercise by bringing the group together as a whole. Ask how they feel about the exercise. Discuss factors in the community that have led to the need for PSS. Acknowledge the PSS's self-identification as change agents and advocates within the community. Recognize their inherent strengths and motivations that will make this program a success.

G. GOAL SETTING (1 hour)

Rationale: Setting personal goals will help PSSs recognize their own strengths and help them to experience personal growth and fulfillment.

Procedure: 1. Ask participants to split into groups of no more than five. One person is assigned as writer. Everyone shares personal learning objectives and goals for training.

2. Bring the group back together to develop a master list of common goals and objectives. Discuss those learning goals and objectives that are personal and those that are programmatic. List separately or star those goals and objectives that you have not planned to cover in this initial training, but would be good topics to cover in an in-service training. Keep the list on newsprint as a reference for all to see.

3. Ask trainees to list their personal goals in their Handbook. Process this exercise by referring back to the training outline. Encourage trainees to continually reflect on whether or not they feel goals are being met and to share these reflections with you.

H. ADDITIONAL TEAM BUILDING EXERCISES II (1 hour)

Rationale: Team and skill building is vital to the success of the project and job satisfaction of the staff.

Procedure: Begin Afternoon with Ice Breakers designed for team building, i.e., pp. 95 and 131 in Games Trainers Play.

I. QUALITIES AND/OR CHARACTERISTICS OF AN EFFECTIVE PSS (½ hour)

Rationale: PSS's come to the training with many valued life experiences and personal qualities. It is important that everyone recognizes these qualities in themselves as the key to their success as a PSS.

Procedure: 1. Open the discussion by saying something like: "Let's start by thinking of a helping relationship you had and what made it special. Tell us about it"; "Let's talk for a few minutes about the qualities and personality traits of the kind of person who will make an effective PSS. Please share with the group one quality or characteristic you have which you think will make you an effective PSS."

2. Go around the room and encourage each person to contribute one such characteristic. Then, if participants still have personal traits to share, give everyone a second change to suggest additional qualities of an effective PSS. Be sure to record these characteristics on newsprint or a blackboard.

Here are a few of the **responses** you can expect to hear:
- Someone who is a caring person.
- Someone with patience.
- Someone who is understanding.
- Someone who treats people equally and who is not judgmental.
- Someone who has had a positive parenting experience and who can be a good role model.
- Someone who likes to be around people.
- Someone who communicates well.
- Someone who is able to make and carry through plans.
- Someone who is street wise.
- Someone who can empathize with people different from themselves.
- Someone who has the strength to tell the truth even though the listener is not going to like it.

Ask trainees: Why is it important to share strengths? Was it difficult for them to do so? Ask if anyone wants to share what they consider a personal weakness. **Possible responses** include:

- It is important to know ourselves.
- We can offer our expertise when needed.
- We will recognize when we need to ask for help.

[**Note:** This is a good time to share strengths and weaknesses so that the PSS trainees can start to develop a support network for each other.]

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Resource Mothers, 1993.

J. ACTIVITIES/TASKS THAT MAY BE EXPECTED OF A PSS (45 minutes)

***Rati*[illegible]cipants ma[illegible]e able to remember and use the new information from the training course more easily if the framework of how it will be needed and used in a home visit is understood.

Procedure: 1. If it was not done in Section D when you or other staff presented an overview of the PIP Project, now is a good time to provide a general framework of what a home visit entails. It would be ideal if you could invite an experienced home visitor to share her story.

2. Use the job description that was prepared for your newly hired PSS. Also use PIP information in *Operations Manual* and **Handout #9** as a sample. The participants may have seen this description at the time they were recruited, but it is useful to discuss their anticipated responsibilities at this time. It will help them focus on the types of skills they will want to develop and/or improve upon during this training.

3. Suggest that participants also refer to the last section of Chapter 1 in the *Resource Mothers Handbook*. It gives a quick overview of the types of activities that home visitors may be called upon to perform. Participants may want to mark all those that are applicable to this program.

4. Some trainees may look at these lists/descriptions and feel somewhat overwhelmed. Ask the PSS trainees how they feel about the job description. Does anyone feel overwhelmed? Being a PSS is a BIG job. No one is 100% prepared for any job. That is why it is so important for everyone to share strengths, develop teamwork and thrive on the multiple talents that they share.

You can also help by pointing out that their life experiences have already laid the foundation for them to undertake these activities/tasks/responsibilities.

5. Lead a group discussion on skills/knowledge they already have. Point out that they probably already know much of what they will be learning together during training. This training will help them recognize bits of information that they knew all along but may not have realized they knew. The course will thus, at times, verify and give credibility to things they know intuitively.

K. TEAM AND SKILL BUILDING (45 minutes)

Rationale: Team and skill building is vital to the success of the project and job satisfaction of the staff.

Procedure: Use Ice Breakers of your choice or pp. 195 and 205 in Games Trainers Play.

L. SUMMARY AND REVIEW (15 minutes)

Rationale: Each session of the [illegible]st be "wrapped up" before moving on to the next unit. "Wrap-up" should be participatory; trainees are the best ones to provide this summary information. This is a good way for the trainer to "check up" on him/herself and learn how much of the information has been internalized by the group. It is a good time to clarify any material/information that was perceived incorrectly, or to review content that needs strengthening. In some of the following units, you may find that, although you have covered all the material, additional time is needed to practice skills. That is why training must always be flexible enough to allow for scheduling changes.

Before moving on to the next unit, be sure to ask participants what they enjoyed about this portion of the training, and in which areas they feel they require further information. practice time, or both. An easy way to do this is to ask each participant to complete a post-unit evaluation form. As discussed earlier, you can also do this verbally. This form is not a test of knowledge. It is a type of process evaluation. Its function is to gather trainees' comments on a particular unit and learn how they perceive their ability to use whatever information was presented. A prototype post-unit evaluation form is included at the end of this unit. Use it, adapt it, or create one of your own.

Procedure:

1. Refer back to the objectives on the first page of this unit and rephrase them so they are questions. Ask for a volunteer to answer each question. For example: "What are the goals and objectives of our PIP Project?" or "What are some of the qualities that make for an effective PSS?" Take turns so everyone is encouraged to participate.

   Or, you may prefer to have a different participant take the lead in summarizing each session, and then ask others to fill in with any important points that may have been overlooked. Or, you may try both methods and see which one works best for this particular group.

2. Distribute the post-unit evaluation form. As this is the first time trainees will have seen it, go through it with them and make sure they understand each question and the type of explanatory comments you want them to provide. Let them know that you will ask them to complete a similar form at the end of each unit. Point out that there are no right or wrong answers, and explain why you are interested in this type of feedback.

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PRIDE IN PARENTING
PRETEST QUESTIONNAIRE

1. What is the goal of the Pride in Parenting Project?

2. Name four qualities or characteristics of an effective Parenting Support Specialist.
    1.
    2.
    3.
    4.

3. List three advantages of going into a mother's home to provide information and support.
    1.
    2.
    3.

4. List three characteristics of active listening.
    1.
    2.
    3.

5. Name five traits found in healthy families.
    1.
    2.
    3.
    4.
    5.

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6. Describe the difference between discipline and punishment.

____

____

____

7. List two ways a woman can protect herself from getting an STD.

1. ______________________________
2. ______________________________

8. List three characteristics of the high violence/abusive parent.

1. ______________________________
2. ______________________________
3. ______________________________

9. List three myths about ethnicity and cultural diversity that are prevalent in our society.

1. ______________________________
2. ______________________________
3. ______________________________

10. At what age do you think babies first begin to:

Smile_____

Fill and dump toys_____

Sit up_____

Walk_____

Play peek-a-boo_____

Say words_____

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11. List three tasks or activities that you as a Parenting Support Specialist may be asked to perform.

    1. ______________________________
    2. ______________________________
    3. ______________________________

12. What do you tell your client who tells you she doesn't want anymore children but she stopped taking birth control pills because they made her feel sick?

    ____
    ____
    ____

13. Can you spoil a two to three month old baby? Why or why not?

    ____
    ____
    ____

14. Is it important that children get all immunizations? Yes___ No___ Maybe___ Why?

    ____
    ____
    ____

15. Discuss two positive and two negative ways of dealing with anger.
    POSITIVE:

    1. ______________________________
       ____
    2. ______________________________
       ____

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NEGATIVE:

1. ______________________________

____

2. ______________________________

____

16. List three warning signs in the postpartum period.

    1. ______________________________
    2. ______________________________
    3. ______________________________

17. Name five social service agencies used frequently by families in need and how referrals are made.

    1. ______________________________
    2. ______________________________
    3. ______________________________
    4. ______________________________
    5. ______________________________

18. You make a weekly visit to one of the mothers. She tells you her baby has been crying all morning. How would you respond. Be specific.

____

____

____

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List thr vays you can ensure your safety on home visits.

1. ______________________________
2. ______________________________
3. ______________________________

20. Name four things mothers can do to stay healthy.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

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POST-UNIT EVALUATION

UNIT COVERED: _____

DATE_______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

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5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

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INTRODUCTIONS: ICE BREAKER EXERCISE

Exercise 1:

Take the nametag of someone else. Find that person and when you do, sit down and talk to her for five minutes. Find out as much as you can about her -- family, where she grew up, hobbies, interesting facts, unique characteristics; then reverse roles. At the end of ten minutes, you will introduce your new friend to the group.

Exercise 2:

Go down into your purse and find one item that is symbolic of or represents something very important about yourself. Share with the group.

Exercise 3:

Share one thing that no one would ever know just by looking at you.

After each exercise, ask participants how they feel. Discuss various feelings that will frequently occur in new situations and while getting to know new people (ie. anxious, embarrassed, shy...). Ask participants what helped them feel most comfortable. Suggest these as strategies to use with clients (ie. listening, providing encouragement and praise, ensuring confidentiality ...).

Source: Unknown

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PRIDE IN PARENTING PROGRAM

TRAINING AGENDA

9:00 - 9:05a.m.	Welcome	Project Coordinator
9:05 - 10:00	Introductions/ Team Building	
10:00 - 10:30	Pretest	Project Coordinator
10:30 - 10:45	Break	
10:45 - 12:00	Overview of the Project Role of Parenting Support Specialist Preview of Training	Intervention Coordinator
12:00 - 1:00	Lunch	
1:00 - 2:00	Program Philosophy	Principal Investigator
2:00 - 3:00	Introductions of Research Project Staff/Trainees	
3:00 - 3:30	Refreshments	
3:30 - 4:30	Brief meeting of Research Project Staff	

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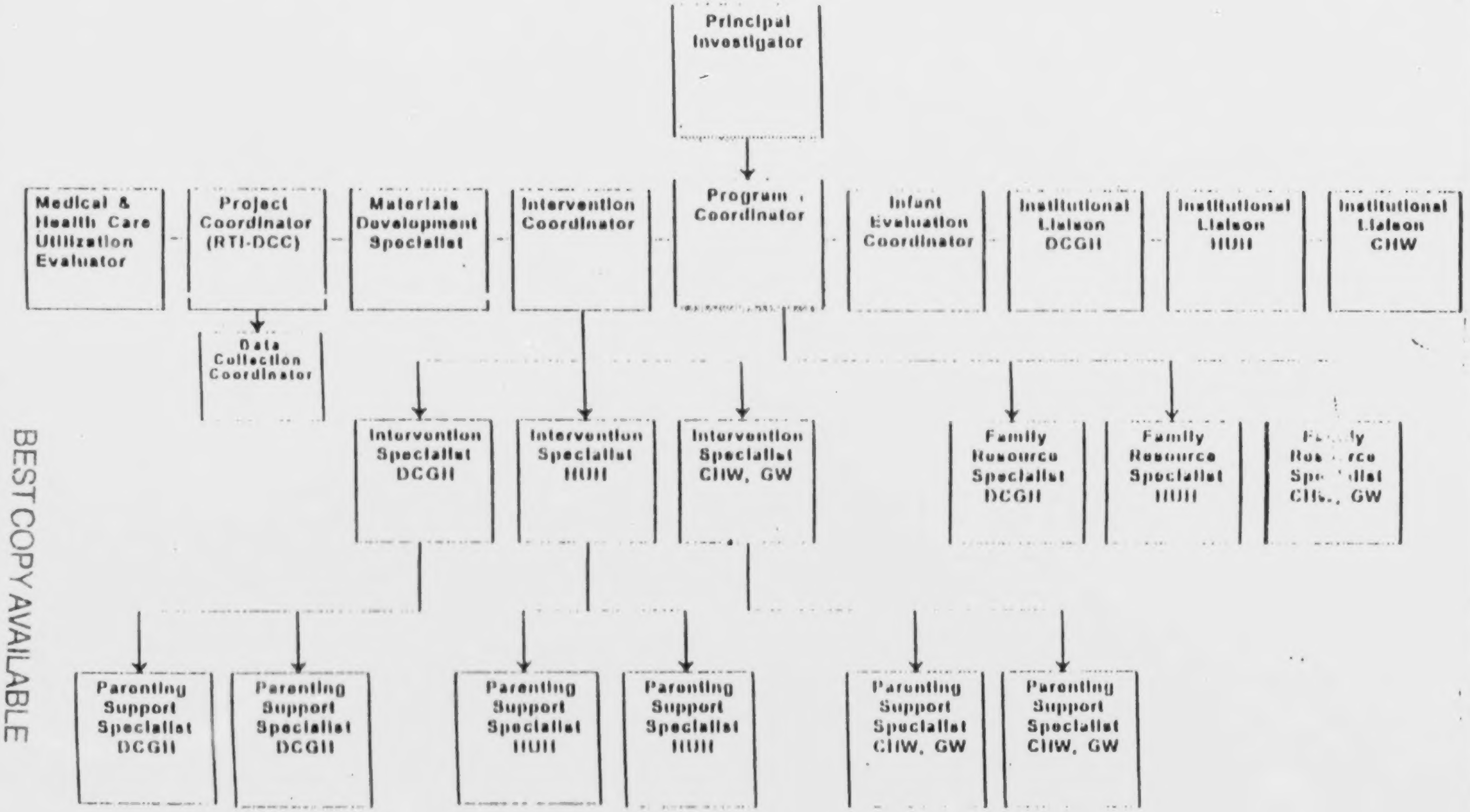
PRIDE IN PARENTING



Principal Investigator

Medical & Health Care Utilization Evaluator

Project Coordinator (RTI-DCC)

Data Collection Coordinator

Materials Development Specialist

Intervention Coordinator

Program Coordinator

Infant Evaluation Coordinator

Institutional Liaison DCGH

Institutional Liaison HUH

Institutional Liaison CHW

Intervention Specialist DCGH

Intervention Specialist HUH

Intervention Specialist CHW, GW

Family Resource Specialist DCGH

Family Resource Specialist HUH

Family Resource Specialist CHW, GW

Parenting Support Specialist DCGH

Parenting Support Specialist DCGH

Parenting Support Specialist HUH

Parenting Support Specialist HUH

Parenting Support Specialist CHW, GW

Parenting Support Specialist CHW, GW

DCGH -- D.C. General Hospital
HUH -- Howard University Hospital
CHW -- Columbia Hospital for Women
GW -- George Washington Medical Center

RTI-DCC
10/11/95

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OVERVIEW
THE PRIDE IN PARENTING PROGRAM

The NICHD-DC Initiative to Reduce Infant Mortality in Minority Populations in the District of Columbia

The National Institute of Child Health and Human Development (NICHD)

The National Institutes of Health Office of Research on Minority Health

District of Columbia institutions

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THE PRIDE IN PARENTING PROGRAM

PRIMARY GOAL

To develop and test a program of interventions for low-income minority mothers with poor/no prenatal care.

PROGRAM OBJECTIVES FOR INTERVENTION MOTHERS

1. To develop a healthy relationship with their babies
2. To understand growth and development
3. To cope with stresses of parenting and everyday life
4. To improve use of health services

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THE PRIDE IN PARENTING PROGRAM

PRIMARY ACTIVITIES

Group 1: Mothers receive services already available at the hospital.

- Family Resource Specialist
- Problem solving and accessing services
- Social services and health care use monitored

Group 2: Mothers receive special services offered by Pride in Parenting.

- Parenting Support Specialists
- Personal, supportive relationship
- Weekly home visits
- Developmental Play Group
- Parent Support Group
- Social services and health care use monitored

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THE PRIDE IN PARENTING PROGRAM

PRIMARY OUTCOMES

- Improved utilization of health care
- Optimal infant growth and development
- Improved parental knowledge, attitudes, skills and behaviors
- Improved social support and competence
- Improved mother-infant interaction

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PARENTING SUPPORT SPECIALIST TRAINING SCHEDULE

Welcome! The following schedule will show you when each topic in the training program will be taught. More specific information will be presented at the beginning of each unit. We look forward to an exciting time together.

The reading assignments are noted on the day before the unit is to be taught. These assignments are to prepare you to begin to think about the information that will be presented.

Weeks 1, 2, and 3 will be held at D.C. General Hospital.

WEEK 1:	**JANUARY**
3 - 5	Parenting Support Specialists will be at individual sites, processing through each hospital.
6	Introduction to **Pride in Parenting (PIP)** and getting to know each other.
9	Introduction continued. Read Chapter 2 in Resource Mothers (RM) Handbook.
10 - 12	Communication and Relationship Building. Read Chapter 17 of the RM.
13	Using Support Materials. Read Chapter 14 of the RM for Tuesday 1/17/95.
WEEK 2:	
16	Holiday
17	Child Growth and Development, Introduction.
18	Child Growth and Development, Birth - 1 Month. Read Chapter 10 of the RM.
19	Postpartum Care and Planning. Read Chapter 11 of the RM.
20	Family Planning. Read Chapters 8 and 13 of the RM.
WEEK 3:	
23	Infant Feeding and Nutrition. Read Chapters 12 and 15 of the RM.
24	Health Care in the First Year.
25 - 27	Child Growth and Development, 1-4 months.

Weeks 4, 5, and 6 will be held at Columbia Hospital for Women.

WEEK 4:	**JANUARY**
30 - 31 and February 1-3	Child Growth and Development, 4 - 8 months.

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WEEK 5:	**FEBRUARY**
6	Beginning Training Programs. Read Chapter 3 of the RM.
7	Coping With Stress.
8	Coping With Stress continued. Begin Working With Families.
9	Working With Families continued. Read Chapter 4 of the RM.
10	Self-Esteem and Feelings.
WEEK 6:	
13 - 17	Child Growth and Development, 8 - 12 months. Read Chapter 18 of the RM for Tuesday 2/21.

Weeks 7, 8 and 9 will be held at Howard University Hospital.

WEEK 7:	**FEBRUARY**
20	Holiday
21	Managing Home Visits
22	MCH Conference
23	Personal Safety
24	Managing Home Visits
WEEK 8:	During weeks 8 and 9, there will be times of joint training for the Parenting Support Specialists and Family Resource Specialists.
27 - 28	Child Growth and Development, 1 - 2 years
March 1	Behavior and Discipline
2	Team Building and Cultural Diversity
3	Health Promotion for Families
WEEK 9:	
6	Children in Violent Circumstances. Read Chapter 13 of the RM.
7	Morning: Identifying Family Needs. Afternoon: Accessing Community Resources.
8	Support Materials
9	Speaker on home visiting
10	GRADUATION -- CONGRATULATIONS!!!!!!!!

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OUTREACH WORKER/PARENTING SUPPORT SPECIALIST

Pride in Parenting is a research project funded by the National Institute of Child Health and Development. This program will be implemented at four different hospitals in the Washington, D.C. area:

Columbia Hospital for Women
D.C. General Hospital
George Washington University Medical Center
Howard University Hospital

The project is designed to work with babies and their mothers who had very little or no prenatal care during their pregnancy. Pride in Parenting will bring new services to these mothers and babies. The focus of these services will be:

- Helping the mother and baby develop a healthy relationship.
- Helping the mother cope with the stresses of parenting and the demands of her everyday life.
- Increasing the mother's understanding of her baby's growth and development.
- Improving the mother's use of health services.

Mothers who agree to participate in this research program will become a member of one of two groups:

Group 1: Mothers in this group will be offered services already available at the hospital (Control Group).
Group 2: Mothers will receive the special services offered by the program (Intervention Group).

Pride in Parenting will then study the ability of mothers in both groups to cope with their lives and especially the needs of their babies, as well as their ability to use health care for themselves and their babies. The project is interested in finding out whether one group does better than the other.

The **Outreach Worker**, also referred to as the **Parenting Support Specialist** in the Pride in Parenting Project, is a very important part of the intervention (special services) delivered to **Group 2.** She will participate in two ways:

1. **Home visits:** These will be weekly visits starting the first week home from the hospital, then every two weeks from five months until the baby's first birthday.

2. **Developmental Play Group:** This will occur at the hospital two times every month from five to twelve months. The Parenting Support Specialist will be assisting the Infant Development Specialist with the running of these groups.

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The Parenting Support Specialist will be required to complete paperwork at the end of both the home visits and the play group.

The Parenting Support Specialist will be responsible for helping every mother and baby on her case load learn about:

- Health care needs and resources in the community
- Parenting and general coping skills
- Infant care and development
- Providing a safe environment for the developing infant

The Parenting Support Specialist will meet these goals by establishing a personal relationship with each mother and baby. Through this relationship, she will become a support person for the mothers and therefore important in their lives. All the requirements of the project will be covered in a 45-day training before the Parenting Support Specialist begins working on the project.

In order to become a Parenting Support Specialist, you must want to help mothers and babies, you must be sensitive to each mother as an individual, while following the guidelines of the Pride in Parenting Project.

Pride in Parenting cares about mothers and babies in the District of Columbia. We are looking for people who care about them, too.

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Unit 2

COMMUNICATION AND RELATIONSHIP-BUILDING SKILLS

In preparation for establishing rapport and trust, making home visits, and building relationships with clients, Parenting Support Specialists (PSS) must understand and be able to use basic interpersonal communication and counseling concepts, skills, and techniques.[1]

Objectives

By the end of this unit, participants will be able to:

- Describe how the PSS's attitudes, feelings, and values impact communication with clients.
- Identify at least three forms of verbal and non-verbal behavior.
- Describe the value of praise and encouragement when working with clients.
- Demonstrate the use of positive feedback during role play exercises.
- Paraphrase and summarize another person's feelings and concerns.
- Describe the difference between open-ended and close-ended questions.
- Describe the importance of good listening skills.
- Explain the importance of confidentiality, and identify occasions when confidentiality cannot be kept.
- Translate medical and technical terminology into simple language.
- Write instructions, information, etc. for a low literate population.
- Define transference and counter-transference and give examples of how it can impact on the client-visitor relationship.
- Demonstrate polite interactions with families.

Time

2-1/2 days

Outline

A. Introduction
B. Perception and Values Clarification
C. Verbal and Non-Verbal Communication
D. Low Literacy
E. Interviewing and Listening Skills
F. Summary and Review

Materials

- Resource Mothers. (1993). Handbook. Sterling, VA: INMED.
- Survey of Attitudes and Beliefs **(Training Aid #1)**.
- Seeing the Woman (Overhead Transparencies) **(Training Aid #2)**.
- Importance of Feedback/Geometric Pattern **(Training Aid #3)**.
- Female Reproductive Organs **(Training Aid #4)**.
- Using Simple Words **(Training Aid #5/Handout #3)**.
- Sample role plays for practicing skill areas covered in this unit **(Training Aid #6)**.

Most of the exercises in this module have been taken from: PATH and the MCH Department, Ministry of Health, China, "Interpersonal Communication and Counseling: Five-Day Curriculum," Washington, D.C. and Beijing, 1990.

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- Five Steps to Behavior Change (**Handout#1).**
- Values Clarification Sheet (**Handout #2**).
- Using Simple Words (**Handout #3).**
- Making Sure Information is Clear (**Handout #4**).
- Tips on working with Low Literate Families (**Handout** #4a).
- Writing for People Who are Low Literate (**Handout #5**).
- Communication **(Handout #6).**
- Types of Questions (**Handout #7**).
- Listening Skills Self-Assessment Form (**Handout #8**).
- Inappropriate Responses **(Handout #9).**
- Careful Listening and Learning: Some Guidelines for PSS (**Handout #10**).
- Overhead projector/transparencies.
- Role Play Feedback (**Overhead #1**).
- Post-Unit Evaluation.
- Post-Unit Test.
- Newsprint, markers, and tape or blackboard and chalk.
- Video Equipment: video camera, tripod, tape, VCR, and television.

Advance Preparation:

- Become thoroughly familiar with the *Resource Mothers Handbook*, Chapter 2, "Building Rapport and Trust."
- Assign this chapter to trainees as background reading.
- Be prepared to model appropriate behavior and communication skills.
- Prepare any additional handouts, as needed.
- Test the overhead projector to make sure it is working properly. See if you need an extension cord, depending upon location of electrical outlets in training room. Have an extra light bulb on hand.
- Try out video equipment. Set up camera to videotape role plays.
- Create appropriate role plays, etc. to use in practice session.
- Choose a definition of transference and counter-transference.

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A. INTRODUCTION (20 minutes)

Rationale: Being able [illegible] successful home visits depends on the Parenting Support Specialist's ability to build strong relationships and gain the confidence of her clients. The better the PSS is at communicating effectively, the easier time she will have establishing trust. By the end of this session, trainees will be more aware of factors that discourage good communication and will have an opportunity to practice positive interpersonal communication skills.

Procedure: 1. **Mini-lecture and discussion.** Because this is a long and demanding skill-building session, start this unit on a positive note. A shared poem or a few words of inspiration can go a long way in encouraging the trainees as they prepare for this session. (**Handout #1** is one example). Allow a few minutes for reflection.

2. Before you work with participants on all the exercises in this unit, you need to "set the stage" and provide a framework for the session.

Give the participants an overview of what to expect. The first sections (A-C) deal with perception and clarifying their own values. Sections (D-G) deal with verbal and nonverbal communication. And the final sections (H-O) focus on interviewing and listening skills and techniques. Then there will be time to put all these exercises together when practicing mock home visiting scenarios.

3. This unit should be worth the time participants devote to it. Let trainees know that, as they work together to improve communication and relationship-building skills, they will be working on techniques that will go far toward expanding their abilities to be empathetic and effective Parenting Support Specialists.

B. PERCEPTION AND VALUES CLARIFICATION

1. SURVEY OF ATTITUDES EXERCISE (40 minutes)

Rationale: The purpose of this and the next exercise is to demonstrate that individuals' values may differ greatly, even within a community, and that people have reasons for holding the values they do. [**Note:** Do not tell participants this at this time. You should be able to elicit this information from them, as together, you process these exercises.]

Procedure: 1. Tape papers labeled "Agree" and "Disagree" to opposite ends of a wall of the room. Hand out "Survey of Beliefs and Attitudes" and have people complete them. Do not write name on form. Ask participants to be honest with themselves and mark the response that best represents their feeling or belief. Tell them there should be no talking among themselves or asking questions.

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2. When completed, hand them in. Pass them back out to people so that people do not have their own paper. Then read a statement and have people move to where the respondent of their paper answered.

3. Read another statement and again ask participants to stand under the sign that best reflects the answer on the paper they have. Continue in this manner, having participants move around.

4. Process this exercise by asking questions such as:
- Did any of your responses surprise you? Which ones?
- How did people respond to different statements?
- How did you feel about other people's responses? Why?

Try to engage everyone in the discussion.

5. If participants are from the same background (race, age, religion, etc.) and if there are varying responses to the statements, encourage the group to discuss why this is so. How does ethnicity or culture affect attitudes and beliefs? How does acculturation – or the degree to which people from a minority culture become "mainstreamed" in the majority culture – affect cultural beliefs?

6. Discuss how personal values or experiences might interfere with teaching. For example, if a PSS was abused as a child, how might that affect the way she teaches a client about discipline?

7. Summarize by saying something like: "Some of you are from similar backgrounds, yet have had some very different responses. People's different experiences lead them to different conclusions. We must first be aware of our own attitudes and beliefs, and then make sure we do not try to impose them on our clients. We must learn to respect others' values and beliefs. This is especially true if we hope to advise and support them." After the group exercise, it may be helpful to tally all responses. If some are overwhelmingly agree or disagree, or if individuals are extreme on certain responses, this may indicate a need to tailor the training in a different way.

2. PERCEPTION EXERCISE (20 minutes)

Rationale: People hear and see things in different ways. Understanding – or at least recognizing – these differences are key to the development of good interpersonal communication.

Procedure: 1. Begin by asking trainees what the word "**perception**" means to them. Let participants discuss this word, as well as the verb form, "**to perceive.**"

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2. A possible response:

- Perception is how we understand what others show or [illegible]

3. Show transparency of woman (**Training Aid #2**). Have trainees examine it carefully.

4. Then ask for volunteers to describe what they see. **Possible responses** might be:

- a young woman; an old lady

5. Probe for more information. For example, ask how old they think she is. Elicit information about the person's features, whether she's attractive, and what she's wearing.

6. Ask for a volunteer to explain how the illustration can be **both** a young and an old woman. Point out that people see and hear things in different ways. Explain that understanding differences in perception is the foundation of understanding communication and relationships. How we perceive others affects the way we communicate with them and relate to them.

7. Introduce the exercises that follow. These were designed to help participants clarify their own values. The exercises should help trainees understand how their perceptions and personal belief systems influence their behavior, which can in turn influence their clients. By first recognizing and understanding their own values, PSS may be able to avoid personal bias when helping, advising, and supporting their clients.

3. VALUES EXERCISE (30 minutes)

Rationale: Values and perceptions influence decisions and behavior. Understanding each others perceptions and values help people to appreciate and respect the various decisions and choices each person makes.

Procedure: 1. Ask the group what is meant by "**values**". Responses may include:

- Values are those things we consider priorities, such as family, happiness, good health, etc. They are things we feel are important.

2. Distribute **Handout #2**, a Values Clarification Sheet, to each participant. Read the instructions with them. Then ask trainees to take five minutes to list their top six priorities. Ask them to **not** discuss their answers while completing the task because conversation might bias their response. Assure them that there will be ample time to discuss answers later.

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3. After trainees have selected their most important values, go through the values, asking who chose the first one as their number one priority, who chose the second one, and so on. Ask a few people to explain why they chose value "x" or value "y" as their first priority.

Alternate: In lieu of the above procedure, ask for volunteers to read their lists of values important to them and then ask why they chose their first priority.

4. Be sure to process the exercise by reflecting on responses. If many trainees have similar first priorities, discuss possible reasons. Similarly, if you find that priorities are not shared, discuss why this might be so – e.g., differences in upbringing, education, life experience, etc.

5. Ask what values the clients might have. Would some of these values be different from the trainees? So different that it might be hard to relate or to communicate with the client?

6. Summarize what has been learned together while doing these exercises on perception and values. Some points to make include the following:
- Everyone has different values.
- Sometimes values are so ingrained that we are not aware of them until we are confronted with a situation that challenges our values.
- By understanding our own perceptions and values, we are better able to appreciate and respect the various experiences that shape the perceptions and values of clients.
- When working with and/or counseling clients, it is important to keep people's differences in mind.
- It is important that clients make decisions based on their own values and situations.

C. VERBAL AND NON-VERBAL COMMUNICATION

1. VOICE CHARACTERISTICS (20 minutes)

Rationale: People communicate on many levels, using many cues, both verbal and nonverbal. When working to establish a good relationship, nonverbal behavior can be even more important than what is actually said. An effective PSS needs to be sensitive to the many behaviors both she and her clients exhibit as a way of communicating feelings. This discussion and the two exercises that follow are designed to help in this sensitization process.

Procedure: 1. Begin these series of exercises on verbal and nonverbal communication by asking participants to give examples of different ways people communicate with each other. Have someone record this list on the board or on newsprint. **Possible responses** might include:

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- touch
- voice
- body movements
- words
- facial expressions
- signing
- eye contact

2. Another aspect of nonverbal communication involves voice characteristics. It concerns **how** something is said, not **what** is said. An effective PSS needs to be very sensitive to the signals that clients may be giving her through their voices. At the same time she must be aware of how her voice can either add or detract from the interpersonal communication she has with clients.

Mention the different characteristics or aspects of a person's voice:
- Pitch – highness or lowness of vocal tones;
- Volume – loudness or softness of the voice;
- Rate – speed of the speech; and
- Quality – sound of the voice.

3. What are some of the nonverbal things that people do when talking face-to-face with another person that show negative emotions or feelings? When discussing this question, suggest to trainees that they look to their own experience–perhaps how they were treated when waiting to see a doctor or when going to a Social Security or IRS office for help. **Possible responses** might include:
- Shuffling papers
- Refusing to make eye contact
- Looking at watch
- Moving about while other person's talking
- Looking bored, distracted

4. Have trainees discuss how these nonverbal behaviors made them feel. When working to build rapport and establish trust with their clients, let trainees talk about what they'd do differently.

2. NONVERBAL EXERCISE: FEELINGS CHARADE (30 minutes)

Rationale: Careful observation can help the PSS clue in to how clients are feeling. The objective of this exercise is to encourage participants to observe and try to interpret nonverbal communication.

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Procedure: 1. Let each participant pick at least one folded piece of paper on which you have written an emotion or feeling. [**Note**: These emotions/feelings could include – but should not be limited to – the following: Anger, Sadness, Pain, Defensiveness, Pride, Fear, Happiness, Impatience, Approval, Disapproval.]

2. Give trainees a few minutes to think about the word(s) they picked. Advise them they will then take turns acting out the emotion or feeling. Then the others must guess what they are trying to convey. They may use facial expressions and body language, but no words or vocal expressions.

3. After several participants have done this, process the exercise by asking them if it was difficult to convey a feeling without words. Why or why not? For those who were guessing, ask if it was difficult to interpret emotions without a verbal explanation. Why or why not? Discuss various characteristics that make it easier or harder to convey or interpret emotions.

4. Have participants discuss what may happen if their clients don't feel comfortable with their PSS. **Possible results** could include:

- She may not be willing to open up
- She may not keep the next appointment
- She may be unwilling to enroll in the program or, if already in it, may drop out

5. Ask participants to share some of their ideas as to things the PSS can do to make sure that her interest and concern is made evident to the client. How will the PSS make the client feel comfortable? Ask for a volunteer to put these on newsprint, as you may want to come back to them during the training. **Possible responses** might include:

- Introduce yourself
- Shake hands
- Speak the client's language
- Don't interrupt
- Establish eye contact (if culturally appropriate)
- Say "Mmmm," "yes," or in some way show you are listening

Help the group define additional behaviors that are culturally appropriate for the clients with whom they will be working. Ask for any cultural differences or taboos that may make any of these behaviors inappropriate.

6. Emphasize some key points before moving on:

- Sometimes people feel uncomfortable expressing their emotions in words.
- It is important to look for (and hence recognize) nonverbal clues to clients' feelings. It is equally important to be aware of the feelings and emotions we may nonverbally communicate to our clients.

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- Remind participants to keep these techniques in mind when making home visits. (They will also have an opportunity to practice them in role plays later on during the training.)

3. VERBAL COMMUNICATION EXERCISE (30 minutes)

Rationale: A person's tone of voice can communicate a message as much, if not more, than words. Recognizing feelings and emotions through tone of voice can help promote honest and open communication.

Procedure: GAME: 1. Explain that a person's tone of voice also communicates different emotions or feelings. Using the same list prepared for the previous exercise, assign trainees different emotions, or let them choose their own.

2. Then ask them each to say the same sentence, for example, "I will be with you in a few minutes," using the emotion/feeling. [**Note:** Any short sentence you like can be used for this exercise. Other examples: "So, you have a new boyfriend," "Please pass the salt."]

3. Let the others guess which emotion is being displayed and discuss how the feeling is shown. Ask which tone(s) of voice they would prefer to hear when they go somewhere for help and why. Whatever they agree upon, let them know that their clients are likely to react the same way, and for similar reasons.

4. Summarize results of game. Mention that, throughout the training, participants will be doing exercises to strengthen these verbal behaviors.

A few more key points to emphasize:

- Interpersonal or face-to-face communication takes many forms. PSS' need to be attuned to their clients' nonverbal as well as verbal cues.
- PSS' will use both verbal and nonverbal language to demonstrate caring and to build rapport and trust.

4. USING PRAISE AND ENCOURAGEMENT (20 minutes)

Rationale: Communicating praise and encouragement can be important for building and maintaining positive self-esteem.

Procedure: 1. Ask participants to brainstorm the meaning of encouragement. Have someone write responses on newsprint or chalkboard. Work their responses into a definition that goes something like this:

- **Encouragement** means the act of giving courage, confidence, and purpose; the action of inspiring with spirit or hope.

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2. Discuss what this word means, more specifically, when working with a client. For example, to provide encouragement means letting the client know that the PSS believes the client can overcome her problems.

3. Discuss some ways the PSS can provide encouragement to her clients. **Possible responses** might be:

- Point out hopeful possibilities
- Tell client she is already helping herself by participating in the program
- Help client find ways to accomplish her goals.

4. Have participants brainstorm the meaning of **praise**. Again, have someone write down trainees' responses. Work these into a definition that goes something like this:

- **Praise** means to extol, commend, or applaud. Praise is positive feedback building on the client's strengths and accomplishments.

5. Again, as above, discuss what the word means in the context of making home visits. For example, to give praise means to build on good or positive behavior, and to comment on the good things a client has done. Encourage trainees to suggest ways they might do this. **Possible responses** might include:

- Compliment the client
- Look for something to admire rather than to criticize.

6. Discuss situations where there does not appear to be anything positive to acknowledge. If a client is doing something that is harmful to herself or her baby, this needs to be brought to her attention. Constructive criticism can be helpful.

7. Make up a few statements that a mother with a young baby might say early on to a PSS. Then ask participants to give an encouraging response. For example:

- "I'm too tired to stay in school."

Possible PSS response: "I know you must be tired, young babies can be a lot of work. You should be proud of yourself for going to school all these weeks."

- "Last time I had a baby, the first 3 months were terrible."

Possible PSS response: "That sounds tough. Let's work together on things that can make these months easier for you and your baby."

- "Getting well baby care is a waste of time."

Possible PSS response: "Tell me why you think well baby care is a waste of time." After the client has described what she means, the PSS can discuss with her pros and cons of well baby care.

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8. Discuss what happened in step #7, when trainees responded to your "client" statements with encouragement and/or praise. Did they find it difficult to find something nice to say? How do they think it made the client feel? How do they think that particular home visit would proceed? Why?

9. Another way to praise is to comment on what a person is doing ie."I can see that you've been preparing your baby's formula."or "You have put away so many of the baby's things." This can give the person a chance to praise herself ie. "Yes I have" or you can say "You must be really proud of yourself" and give the person a chance to respond.

10. Be sure to remind trainees to refer to Chapter 2 of the *Resource Mothers Handbook* where they can read more about the importance and usefulness of giving praise and encouragement. Also emphasize some key points before moving on:

- ✓ Praise and encouragement are more effective in helping a client acknowledge and solve her problems than are scolding and condemning.
- ✓ To praise does not mean to patronize. It is easy to sound condescending, not only in the words chosen but in the tone of voice used. If you are aware of this possibility, you can guard against it. Ask for examples.
- ✓ Remember that clients need praise and encouragement but, above all, they need respect. Giving unmerited praise does not show respect. (Discuss this idea more fully, if warranted.)
- ✓ You will empower your clients by treating them like responsible adults, remembering that even responsible adults need praise and encouragement. (Let participants know that they will also discuss empowerment in the next unit. Here's a good opportunity to emphasize that so many of the tools, techniques, and skills they will be talking about and practicing during training are interrelated. Topic areas don't neatly divide themselves into discrete units.)
- ✓ Praise and encouragement are also important for building and reinforcing positive self-esteem.
- ✓ Modeling how to give praise and encouragement can help clients learn how to praise and encourage their children.

5. THE IMPORTANCE OF FEEDBACK (30 minutes)

Rationale: Effective communication requires ongoing clarification. Verbal and nonverbal feedback can help clarify communication.

Procedure: 1. Advise trainees that the exercise they are about to observe (and/or participate in) illustrates the importance of feedback in the communication process.

2. Ask for two pairs of volunteers from among the participants. [**Note:** If you are only working with a small number of PSS trainees, you can adapt this exercise so that staff or other "outsiders" are recruited to help you.]

3. Take the two pairs to another room away from the other participants. Tell both pairs that they will be given the same drawing. One person in the pair will be the "describer," the other one will be the "illustrator." The describer **must not** show the drawing to her partner.

Instructions for Pair A: One partner describes the drawing while the other one **illustrates** it, in front of the other trainees, on newsprint or the blackboard. The rules however, include:
- "Describer" is not allowed to repeat her instructions or give any nonverbal messages.
- "Illustrator" is not allowed to ask questions or use any kind of nonverbal communication.

Instructions for Pair B: Again one describes while the other one illustrates, but this time the rules are:
- "Describer" **is allowed** to repeat instructions in any way she wants. She can also use nonverbal communication techniques.
- "Illustrator" is encouraged to ask questions and may use nonverbal language.

4. Before bringing Pair A into the training room, show the other trainees a copy of the drawing, found in **Training Aid #3**. (Or, if your group is large, make and use a transparency to project the image for all to see).

5. Put the drawing out of sight and bring in Pair A. Give illustrator a marker and a clean piece of newsprint. Give the describer a copy of the drawing. Before describer starts giving instructions, tell the participants the rules that Pair A will follow. Give Pair A five minutes to complete their part of the exercise, and then tell them to stop.

6. Cover up the drawing completed by Pair A. Bring in Pair B. Repeat the same process as above, but this time the rules are different. Explain the new rules to the other trainees.

7. Compare the two drawings with the original. Extract observations from the trainees. Which drawing is closer to the original? (Pair B's should be). Why? Some **possible reasons** you will hear include:
- The describer in Pair B could repeat the instructions.
- The describer could use hand gestures and other nonverbal communication techniques.

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8. Process this exercise by discussing the fact that effective communication needs constant feedback – either verbal or nonverbal – and repetition. PSS' will probably need to repeat important instructions and encourage clients to ask questions.

6. "TRANSLATING" MEDICAL AND TECHNICAL TERMINOLOGY INTO SIMPLE LANGUAGE (1 hour)

Rationale: This exercise is meant to sensitize participants to the fact that "simple language" is often better understood than sophisticated medical and technical terms. [**Note:** Throughout this training, you have an opportunity to model this concept yourselves, by using lay terms rather than technical terms when interacting with participants.]

Procedure: 1. Ask for one volunteer to "play" your client. Pretend you are a PSS and explain some phenomena to your client using medical terminology. Take a few lines from a medical textbook or say something like the following: "About the time of ovulation, the fimbriae of the oviduct cover the site of ovulation. The cumulus cells appear to be important in the pick up and transport of the egg by the oviduct. Tubal cilia and peristalsis contribute to the transport of the egg down the fallopian tube." The client can look confused or intimidated.

Now, repeat your performance but, this time, use lay language and a picture **(Training Aid #4)**. If you went with the example provided above, this time you might say: "The finger-like ends of the woman's fallopian tube help to take the egg down to the womb." This time the "client" should demonstrate understanding.

2. Show overhead of **Training Aid #5** and give out **Handouts #3**, "Using Simple Words", showing some examples of how to use simple words instead of technical or "proper" terminology. Ask participants to try practicing using these words in the exercise.

For the exercise "Using Simple Words", have people take out a piece of paper. Read the "jargon-filled" statements and ask them to restate the phrase. Ask for volunteers to give their restatements.

3. Discuss other examples or any questions the participants have. Discuss the pros and cons of using slang or other "street language." When educating clients about family planning and infant care, how does one decide how graphic to get and what terminology to use? Elicit trainees' reactions and comments. Sometimes this can be quite controversial. Some lay home visitors speak to their clients using slang. Others say they would never use such language, and they feel they should act as a role model and not use slang or crude terms. Often, with very little instruction, terms that are not

offensive but are "proper" can be used with clients without the need for medical jargon.

4. As a summary of these last few sections, distribute Making Sure Information is Clear (**Handout #4**). Go over it with participants and suggest they keep it for future reference. Be sure to ask for any questions before moving on.

7. SLANG EXERCISE (1-1/2 hours)

Rationale: Many PSSs may be uncomfortable talking about sex. This exercise puts all the vocabulary and slang 'on the table' and lets people 1) realize what level of comfort or discomfort they each have, 2) practice saying the words so they are more comfortable (desensitizing), 3) learn what 'street words' they may hear so that they understand what the client is talking about, 4) discuss what words they want to use with clients.

Procedure: **Exercise**: 1. Pass around sheets of paper that have one word or phrase at the top. As they are passed around ask each person to write down any expression or word they have ever heard for this. Papers are passed around until no one has anything to add. **Words on the top of pages should include:** bowel movement, condom, vagina, having sex, oral sex, boyfriend, sexually transmitted disease, Aids, extra marital affair, abortion, miscarriage, anus, anal sex, got pregnant, oral contraception, prostitute, homosexual, penis, husband, wife, rape, live-in partner, masturbation, baby girl genitals, baby boy genitals, navel, umbilical stump.

2. Handout completed pages at random.

3. Ask each person to read aloud the list in front of them. After the list is read, discuss with the group:

a. Which 2 to 3 words are the most commonly used. Put an asterisk next to these words or phrases.

b. Talk about whether there are age differences that make some words more or less appropriate to use with younger moms, older moms, grandmothers; discuss which words they would use with their clients. Repeat this with each page.

D. LITERACY EXERCISE (2 hours)

Rationale: Many clients may have a low literacy level. One purpose of this program is to make information accessible to all clients. Being aware of issues related to low literacy will be important in meeting this goal.

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Procedure: Using **Handouts 4a and 5**:

1. Explain what makes things easy or hard to read.
2. Explain how to print clear instructions without jargon.
3. Do a series of exercises:
    - On the overhead, show examples of instructions that are written inappropriately.
    - On their own paper, have each person write out how they would leave a note for a mother who is low literate.
    - Go around the room and give individual comments as people complete this task.
    - As a group, compare what they did; discuss what was difficult and why.
    - On the overhead, show how you wrote notes that are appropriate for a low literate population; review how there is more that one right way to do this.

E. INTERVIEWING AND LISTENING SKILLS

1. RESPECT, GENUINENESS AND EMPATHY (30 minutes)

Rationale: Interpersonal communication skills are key to the success of the PSS. This unit reminds the PSS of the skills they may need to practice to maximize the effectiveness of their communication. It should also get them thinking about how their own qualities, characteristics, and "caring nature" can be used to facilitate good face-to-face communication between themselves and their clients.

The following sections are designed to help trainees to develop interviewing and listening skills. Almost everyone is either a good talker or a good listener. It's much more unusual to find people who are good at both. Just being aware of one's behavior when someone else is talking is a good first step to making changes and working to improve one's communication skills.

Procedure: 1. **Mini-lecture and discussion.** Begin by summarizing the above rationale so participants don't lose sight of the focus of this unit. Assure them that, although you seem to be rapidly covering many topics, they can review the concepts in the *Resource Mothers Handbook*, and will have an opportunity to practice all the characteristics and skills that make for good interpersonal communication.

Before doing exercises designed to demonstrate how well they hear and understand what others tell them, explain and discuss three words: **respect, genuineness and empathy (Handout #6).** These characteristics are of

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critical importance to any PSS who needs to establish effective helping relationships with others.[2]

2. Ask if anyone wants to comment on, or define, one of these words. They will probably all have something to say about **respect** and **genuineness.** You might **summarize** by writing a few definitions on newsprint:
- ✓ **Respect** is the ability to treat another person with dignity and with a feeling that he or she is worthy of being understood.
- ✓ **Genuineness** is the ability to convey sincerity in both words and actions.

3. Have participants share experiences when they showed either respect or genuineness, or both.

4. Discuss **empathy** last, as the word may be less familiar to the trainees and require more explanation. **Empathy** is the ability to put ourselves in "another person's shoes" in order to view an experience from that person's perspective. It is often confused with **sympathy**, but the two are not synonymous. Sympathy doesn't involve the degree of understanding that empathy does.

Being able to **empathize** is an important skill, and one that may not come naturally. Empathizing means being focused on the other person instead of being focused on ourselves. When we empathize, another person's experiences become our own, at least temporarily.

5. Discuss with trainees what empathizing entails. Here's a summary of the procedure.
- Listen to what the other person is saying. Concentrate on nonverbal behavior as well as on the words being spoken. Actively care about what has happened to the person.
- Try to recall or imagine how you, the listener, would feel under similar circumstances.
- Take what you know about the person and think about what the other person is feeling. (Be aware that it may be different from what you would feel in similar circumstances.)
- Say something that indicates your sensitivity to the other person's feelings.

6. Ask trainees what skills/attitudes are needed in order to be able to empathize. **Possible responses** may include:
- open-mindedness
- imagination
- a genuine desire to understand the other person

Wasik, B., Bryant, D., and Lyons, C., "Home Visiting: Procedures for Helping Families," Sage Publications, Newbury Park, CA, 1990.

7. Summarize by giving trainees time to voice their thoughts and opinions about these skills/attitudes. Ask if anyone has experiences to share of times they were empathetic. How does it feel to be empathetic? In terms of helping clients, how would being empathetic vs. sympathetic affect the helping relationship?

2. PARAPHRASING AND SUMMARIZING CLIENTS' FEELINGS AND CONCERNS (1-1/2 hours)

Rationale: One aspect of the PSS's role is to help her clients understand their feelings so that they can better cope with problems. The following exercises are designed to help participants paraphrase and summarize clients' concerns. The exercise is designed to bring out the trainees ability to convey respect, genuineness and empathy.

Procedure: 1. **Mini-lecture.** Explain that one way to initiate a dialogue that may help a client deal with some problematic situation and make an appropriate decision is by accurately reflecting the client's feelings and concerns.

2. Model how this process of reflecting works. Two trainers (or you and an assistant) can demonstrate this reflection process by role playing. One reflection scenario might go like this:

> "You feel angry because you waited in the prenatal clinic all morning to be seen and now you never want to go back."
>
> "You feel upset and also angry because you asked your boyfriend to do something and he didn't do it, and now you want to make him understand the seriousness of his neglect."

3. Ask trainees for one example of something a client might say and then model for them what you, as a PSS, might say in response.

4. Then ask for volunteers in groups of two to role play the following situations–or others you have substituted. The PSS trainees should try to reflect, or summarize, what the client is feeling. You may want to write out the client statements on notecards ahead of time and have the group pick a card.

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Possible Client Statements:	**Possible Parenting Support Specialist responses** (but trainees may come up with others):
a. My life is going very well. We just had our first child and I want to wait awhile before I get pregnant again.	a. You sound content with your situation and are ready to learn about family planning options.
b. Just give me medicine to stop my baby's cough.	b. You sound worried about your baby's illness.
c. My mother-in-law is always nagging me. Nothing I do is right.	c. It sounds like you are feeling frustrated and angry with your mother-in-law.
d. My husband beats me whenever I do something wrong. I don't like it but he is right to do it.	d. I'm hearing that you feel guilty for the things your husband says you do wrong.
e. My baby was fine when you convinced me that she needed a vaccination. Now she has a fever and is fussy.	e. You sound angry and worried because your baby is feverish.

5. Suggest that trainees think of summarizing and clarifying feelings as "door openers," ways of getting their clients to "open up" and think about options for future action. How else can the PSS encourage the client to talk in ways that will help them establish rapport? Ask participants to identify some other "door openers." **Possible responses** are:

- "Yes"
- "Uh huh"
- "Tell me more"
- "That sounds interesting"
- Touch, smile, nod, lean toward client
- "I understand what you're saying"

6. **Activity.** Ask trainees to take 5 minutes to write down a problem they might be having–with a relative, housing, a doctor ,etc..

7. Have them divide into pairs and take 5-minute turns talking about the problem they have written down. The listening partner should attempt to reflect or summarize, but not judge feelings expressed.

8. After completing the exercise, **process** it by discussing the following questions:

- Why is it important to summarize your client's feelings?
- Were you able to summarize your partner's feelings accurately?
- How does it feel?
- How did it feel to ask the questions?

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9. Before moving on, emphasize that accurate reflection and acknowledgement of feelings are necessary and critical to the process of relationship-building. Before a client is ready and willing to trust the PSS enough to "open up" and ask for help and advice with problem situations, she must first **believe** that the PSS **hears and understands** her feelings and individual needs and concerns.

3. AGE DISCUSSION (1 hour)

Rationale: Being older or younger than a client can effect the interaction. This exercise and discussion was intended to explore preconceived ideas about age and how clients may react to the home visitor based on how old she is perceived to be.

Procedure: 1. Go to the first PSS and ask the group how old they think she is. Each member of the group guesses and tells why. The person then tells the group her real age and the group briefly discusses the discrepancies.(The person might bring up how she is always perceived as younger or older and what she does about it ie. how she dresses, slang she uses, makeup, etc.). Do this with each member of the group.

2. Group the people by age including the facilitator/ trainer after everyone has divulged their true age . Age groups could be 20-29 years, 30-40 years, etc.

3. Pick one age group at a time. First, ask them to talk about their concerns about visiting mothers of different ages. Second, ask the other age groups to give more insights or hints on what this particular age group can do, or should not do, to win the confidence of women in their respective age groups.

4. TRANSFERENCE AND COUNTERTRANSFERENCE (½ hour)

Rationale: Although this is not a program for psychotherapy, transference and countertransference may occur. It is important for the PSSs to be aware of this in order to work most appropriately with the clients.

Procedure: 1. Introduce the concept of transference and countertransference. Define the terms. Briefly touch on the possible consequences for the home visitor as well as the mother.

2. Remind trainees that the goal of their intervention is not psychotherapy. Discuss the limits of their interaction and the general differences between support and education, and psychotherapy.

5. TYPES OF QUESTIONS (3 hours)

Rationale: Asking appropriate questions can open doors to further understanding and communication. Some questions are "door closers" and discourage the client from

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saying what she really feels. She will know from the question what answer is expected of her, and will most likely respond accordingly.

Procedure: 1. **Discussion**. Distribute **Handout #7,** Types of Questions, to participants. Go over the four types of questions and list them on newsprint. Make sure everyone understands the different types of questions. (To simplify this exercise you may wish to use just "open-ended" and "close-ended" questions and adjust the exercise accordingly).

2. Ask participants to identify the types of questions the Parenting Support Specialists used in the previous role plays.

3. Practice using "open-ended" questions. Give participants several "close-ended" questions to change to "open-ended" questions. Have everyone share their attempts. Give participants a simple situation, ie. On the first visit to a new mom, she is visibly upset. How can you sensitively find out what is bothering her?. Have them ask "open-ended" questions to elicit information.

4. Conclude this session by pointing out that tone of voice is very important when asking questions in a non-threatening, non-judgmental way.

6. LISTENING SKILLS SELF-ASSESSMENT (15 minutes)

Rationale: Careful listening is important in establishing good communication. Self-assessment is a good way to identify what listening skills need improvement.

Procedure: 1. **Activity.** Hand each participant a copy of **Handout #8,** Listening Skills Self-Assessment. Go over the instructions with the group to make sure everyone understands its purpose. Read each statement aloud and allow time for trainees to reflect and mark the column that best describes themselves.

2. Let participants know that this is for their own personal benefit. It should point out to them how they can improve their listening skills. They can keep the sheet for future reference. Responses that include "Almost Always", "Usually" or "Sometimes" indicate poor listening skills.

7. LISTENING PRACTICE AND LISTENING SKILLS EXERCISE (45 minutes)

Rationale: Careful listening takes practice. Often perceptions, values and close-ended questions get in the way of careful listening.

Procedure: 1. **Mini- lecture and discussion.** Explain that when asking questions, it is important to listen to the answers. That sounds obvious, but many people don't do it. We're so busy thinking about what we want to say next that, although we hear, we aren't **really** listening.

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2. Ask trainees to break into groups of three. Ask them to select a topic to discuss – preferably something that would encourage differences of opinion. Pick topics from the exercise on attitudes and beliefs (Training Aid #1) that showed disagreement or use other topics of varying levels of controversy, such as dieting, toilet training and abortion. Note: After the topic of greatest controversy, discuss and reinforce the idea that we all have our own opinions and must be able to be non-judgmental if a client does not share our viewpoint.

3. Explain the rules for this exercise: One person begins the conversation, talks for a minute (or less) and then stops. The second person must summarize what the other said in a non-judgmental fashion before continuing and giving her own viewpoint. Then the first person repeats the process, summarizing what the second person said (again, non-judgmentally) and then adding her thoughts. The third person will serve as observer and make sure the rules are followed. (If you don't have enough trainees, you can bring in other staff or volunteers to participate in this exercise.)

4. Demonstrate how to do this exercise with another trainer or with a staff colleague or volunteer. You can use the following example or, better yet, make up one of your own.

Person A: I think hot pepper is bad because it is harmful to the digestive tract.
Person B: You said that you think hot pepper is harmful to the digestive tract. I find that it helps cleanse the system.
Person A: You think hot pepper helps cleanse the system, but I think it causes diarrhea.
Person B: Etc.

5. Give each group five minutes for their discussion. The observer then gives her comments to the two discussants. Then ask them to change roles so that everyone has a chance to take part in a discussion (as well as observe).

6. Process the exercise by asking trainees what they thought of it. What happened? Was it difficult to follow the rules?

7. Ask trainees for their ideas as to skills and/or behaviors the PSS should exercise in order to be a good "active" listener. Have someone record the suggestions on newsprint. **Possible responses** might include:

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- Concentrate on the client
- Be attentive
- Don't interrupt
- Summarize, reflect
- Give nonverbal feedback (like nodding, smiling, saying "Mmmmm," leaning forward
- Ask for clarification

8. Next discuss with trainees those listening responses that can create problems. Let them know that sometimes even the best communicators respond in ways that are bound to be a "turn off" to the speaker. Ask if anyone can think of examples of inappropriate responses. Use **Handout #9**, Inappropriate Responses.

a. **Irrelevant response.** It bears no relationship or relevance to what has been said. Thus, it ignores the "sender" entirely. Example:

Person A: My boyfriend won't let me visit my cousin in San...
Person B: Hey, Chuck starts a new job tomorrow.

b. **Changing the subject.** This response suggests acknowledgement of what the other person was saying but changes the subject. Example:

Person A: My boyfriend won't let me visit my cousin in San Francisco.
Person B: Well, boyfriends are like that. Hey, Chuck starts a new job tomorrow.

c. **Incongruous response.** This occurs when a nonverbal message appears to conflict with the verbal message. Example:

Person A: We really accomplished a lot by doing these exercises.
Person B: (Rolling her eyes and looking bored) Yes, I sure learned a lot.

d. **Interrupting the speaker.** Interruptions means that the listener breaks in before the other person has finished a statement. This can happen because: 1) she believes what she has to say is superior to what the other person is saying; 2) she believes she knows what the other person is going to say and she wants the other person to realize she already knows; 3) she is not paying careful attention; 4) she is excited by what the speaker is saying and wants to hurry the conversation along. Example:

Person A: I'm worried about the way my boyfriend...
Person B: I see... your boyfriend is really temperamental, but I don't think that's a big problem.

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After going through these different kinds of inappropriate responses, ask participants to give examples of real conversations they have had where people responded in a similar fashion. How did it make them feel? Why? Similarly, if PSS' ignore a client's statement, what effect may it have on the client?

9. As you summarize this session, emphasize key points:
   - Listening is a skill that requires constant practice.
   - Summarizing the main points is good discipline for listening, as it helps confirm to the client that she is being understood. Often the PSS is able to point out issues or emotions of which a client may not be aware, particularly when a feeling is communicated nonverbally. This can provide the PSS with additional information which she and the client can then use when working together to assess needs, solve problems, and/or in some other way help the client take control of her own life.

10. Distribute **Handout #10**, Careful Listening and Learning: Guidelines for the PSS. Ask participants to look over this summary sheet on listening skills. Then ask for one volunteer to share the five main points with the group. Suggest that trainees keep these guidelines for future reference.

8. MAINTAINING CONFIDENTIALITY (30 minutes)

Rationale: Parenting Support Specialists must protect the confidentiality of information their clients share with them. At the same time, there will be occasions when Parenting Support Specialists need to share private information with the Supervisor in order to best serve the client.

Procedure: 1. **Discussion.** Begin by engaging trainees in a discussion of keeping confidential all information they will hear on the job. Refer trainees to Chapter 2 of the *Resource Mothers Handbook* where the importance of confidentiality is addressed.

2. Ask trainees to think back to a time when they told someone something in confidence and that person did not maintain confidentiality. What happened as a result? How did they feel?

3. Ask trainees if they can think of times when the Parenting Support Specialist should not maintain confidentiality. What are they? **Possible responses** might include:

- When the PSS sees or hears something that makes her suspect that the client or her family's safety or well-being is in jeopardy.

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- It is mandatory to report certain confidences, like evidence of child abuse.
- Problem situations in which they feel they need the input of their Supervisor, and perhaps, other professionals in order to help the client.

4. This is an appropriate time for you to invite the PSS' Supervisor to discuss with trainees examples of situations where the PSS should share pertinent information with a professional. Other topics the Supervisor might discuss that relate to this topic include:

- Any specific rules your program has established about ways of maintaining the confidentiality of people participating in your program.
- How the PSS should discuss the issue of confidentiality with clients during the first home visit.
- Your organization's position as to what a PSS should say regarding when she may disclose information to the Supervisor.
- Your organization's policy on assigning a friend or family member to a PSS.
- Protecting client records – perhaps by never leaving them around the house or in an unlocked car.
- The rights of a client to ask to read anything the PSS has written about her. (Let trainees know that later in the training when we discuss documenting and assessing home visits, there will be more discussion of this and the importance of having PSS record only the facts, without judgements and guesses as to what's going on.)

5. Make sure trainees have an opportunity to ask questions so that they fully understand your program's policies regarding confidentiality. [**Note:** This may be a good time to share reporting requirements for suspected child abuse. Have handy a copy of our project's policy on handling this.]

9. OBSERVATION AND ITS IMPORTANCE IN HOME VISITING (15 minutes)

Rationale: Observation may be the most important skill a PSS needs. Clues about a client's emotional and physical well-being can be observed. Observation skills are hard to teach. But observation is something that everyone can learn to do better. We can do this just by being aware of where we are, what we are seeing, and what is going on around us.

Procedure: 1. **Discussion.** Ask trainees what the words "to observe" and "observation" mean to them.

2. Ask for a volunteer to close her eyes and describe any paintings or pictures on the walls of the room, whether or not there is a calendar and, if so, to describe it; the color of the walls; what the light fixtures look like; what the other participants are wearing, etc.

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Pick up on one item she could not recall, for example, the content or color of any painting, and have the group discuss why they think this was not mentioned. Do any others admit to not remembering colors, fabrics, etc. in the room? Does everyone now know what the pictures look like? Why?

3. Discuss with trainees possible **reasons** for feeling that observation is such an important skill. Probe: What are some of the things a PSS can learn, from observation alone, during a home visit? **Possible responses** might include:

- All about the environment in which the client lives
- Safety and security issues
- Something about her possessions and how she spends her time and money, e.g., does she have furniture for the baby, TV, video, books and magazines?; what's in the refrigerator and on the kitchen shelves?; any children's creative playthings/toys (if she has older children)?; are furniture and appliances in working order?
- Insights into personal habits such as neatness and cleanliness.
- All about how family members interact; what's going on within the family.

4. Observation also gives a PSS insights into the client's lifestyle. Discuss how values and perceptions may influence a PSS observation skills.

10. WORKING TO ESTABLISH RAPPORT AND TRUST WHEN MAKING HOME VISITS (4 hours)

Rationale: Establishing rapport and trust requires all the skills learned in this unit. Practice time is **very important**. It's only by practice that the PSS becomes comfortable enough with new skills so that these skills become "second nature" – or something she does routinely.

Procedure: 1. Make sure trainees are familiar with the *Resource Mothers Handbook*, Chapter 2, Building Rapport and Trust. First discuss the meanings of the words rapport and trust (definitions are in the chapter) and why it's such an important challenge for all PSS' to build rapport and trust.

2. Discuss what it means to build a relationship with another person. Have trainees share their personal experiences. Is relationship-building easy or difficult or somewhere in between? Why? Is it something that happens quickly or does it take time? Again, encourage participants to draw from their own background and share experiences with the group. What allowed a relationship to grow? Was it trust, honesty, open communication, understanding of values, etc.?

3. Ask trainees what things they will do to build rapport with their clients and promote a working relationship based on trust.

They should respond with examples from previous sessions **and** from the chapter – e.g., having a positive attitude, showing empathy, being a good listener, making oneself clearly understood, using praise and encouragement, etc.

What has happened within this group to build rapport and trust? Elicit many examples, write on newsprint, and discuss the process.

4. Modeling a situation is an excellent way to help trainees "see" how relationships can be built. Pick a role play scenario and demonstrate what a PSS might do and say. Have a co-trainer or a program staff person play the role of the client. For the demonstration: The mom is very overwhelmed and breaks down crying. After the demonstration, be sure to discuss how to handle crying, how to gauge the level of distress, how to build rapport and find out what problems exist.

Training Aid #6 provides one case history and many role play situations. [**Note:** These are only examples; you and/or other program staff are encouraged to make up your own or to use those that colleagues in other programs used and found effective.]

When modeling a home visit, you don't have to do everything perfectly. In fact, a good learning technique is to ask participants for their critique and feedback as to parts of a conversation that went well and parts that failed, followed by a discussion of **why**. Emphasize that we all learn by making mistakes.

Allow 15 minutes for each role play. Focus on building rapport on the first visit and being observant and non-judgmental.

5. Have each trainee pick a partner. Give each team a different scenario. As they act out the role plays in front of the group, they should trade off and take turns "playing" the PSS and the client.

6. Videotape all role plays and critique as a group. Use overhead #1 as a guide. If there are specific issues related to individual participants, review individually.

7. Repeat all role plays with different trainees as the Parenting Support Specialists but the same PSSs as the mothers.

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F. SUMMARY AND REVIEW (20 minutes)

Procedure: 1. Refer back to the objectives on the first page of this unit and rephrase them so they are questions. Do trainees feel the objectives have been met? Ask for a volunteer to answer each question. Encourage everyone to participate.

2. If your program plans to do a process evaluation at the end of each unit, distribute a copy of this form to each trainee at this time. A sample evaluation form is included in this unit.

3. Distribute Post-Unit Test.

Adapted with permission from Resource Mothers, 1993.

SURVEY OF ATTITUDES AND BELIEFS

The purpose of these questions is to make you really think about the personal attitudes you bring with you during home visits.

Instructions: There are no right or wrong answers. Think about how you personally feel. Be honest with yourself. Do not write your name on this page. Pick the answer that is closest to how you feel:

1 = I strongly agree
2 = I agree
3 = I'm just not sure
4 = I disagree
5 = I strongly disagree

_____ 1. The biggest reason a mother doesn't keep her baby's doctors appointments is that she doesn't understand that well baby check-ups are important.

_____ 2. A mother should never send her baby to the doctor with a relative. She should always go.

_____ 3. It's best not to hold a baby too much because it will spoil the baby.

_____ 4. Spanking is still the best way to get toddlers to mind.

_____ 5. It's best for a new mother to be sure to keep the baby's father happy and meet his needs even if she is tired.

_____ 6. It is best to wait until marriage to try to have a baby.

_____ 7. Babies born to single mothers turn out just as well as babies born to couples.

_____ 8. Child abuse is more of a problem among poor families because many poor people don't really care about their children.

_____ 9. Women who have lots of children are more interested in increasing welfare payments than in the child.

_____ 10. Women who don't use birth control are irresponsible and lazy.

_____ 11. Women who have a number of different fathers for their children have questionable moral character.

_____ 12. A father who never has money to pay for his baby's needs but who always wears "the latest" does not care about his children.

_____ 13. Researchers care more about their research than the people they study.

_____ 14. A mother who uses drugs during pregnancy doesn't care about her unborn child.

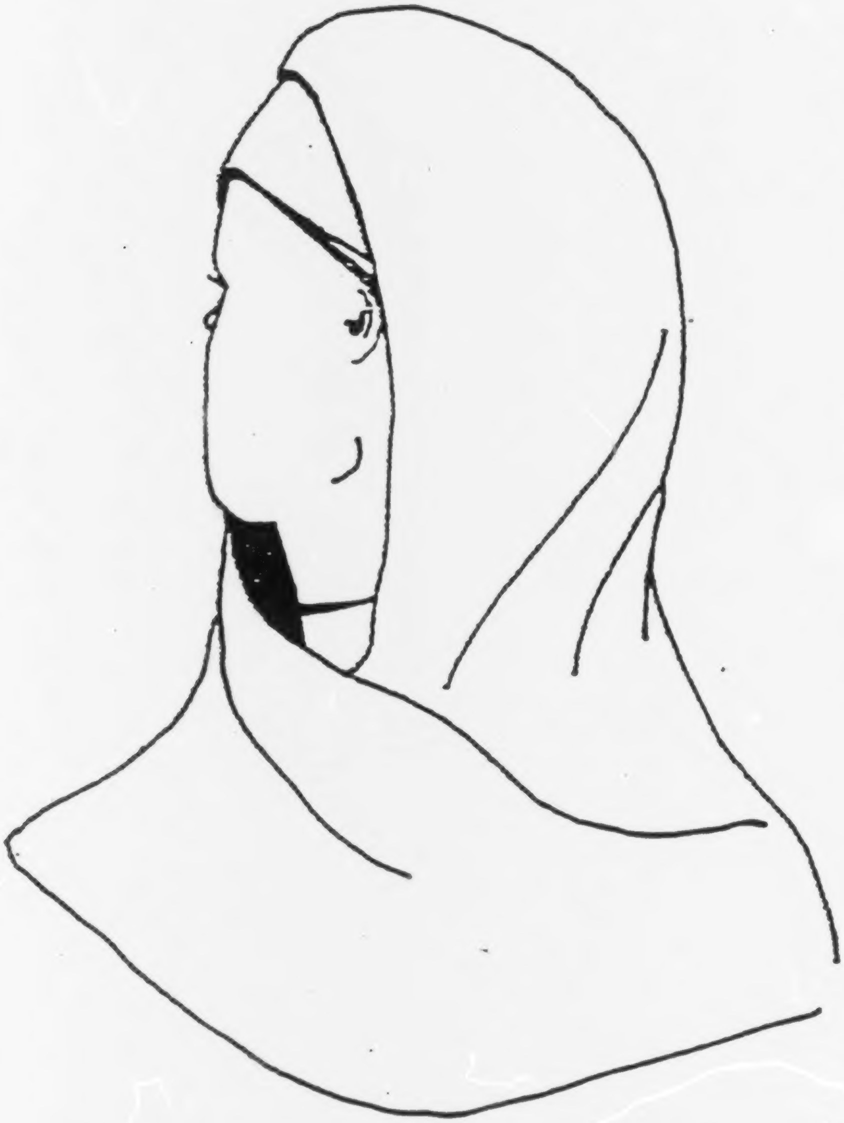
_____ 15. People whose homes are always a complete mess can't organize anything else in their lives.

_____ 16. People with religion in their lives are more loving to their children.

_____ 17. Mothers who consistently aren't home when you show up for an appointment at their home should be dropped from the program.

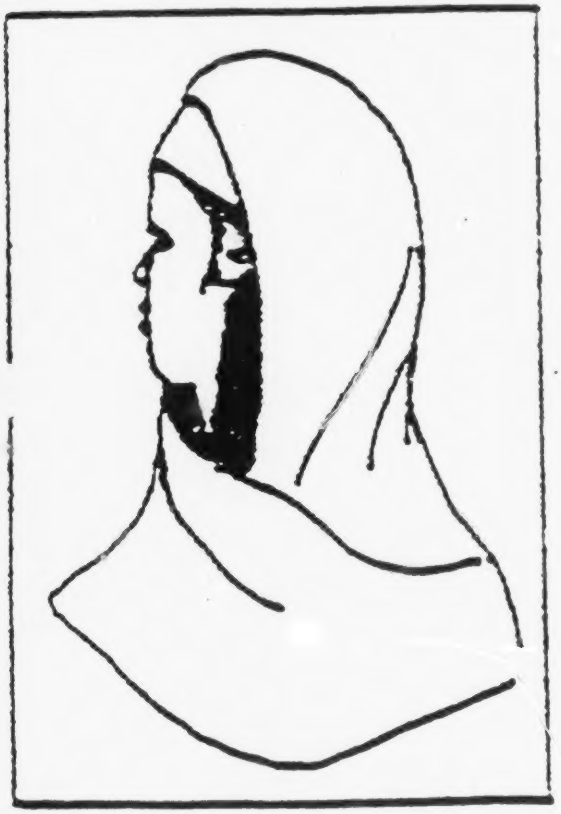
Adapted with permission from Resource Mothers, 1993.

SEEING THE WOMAN

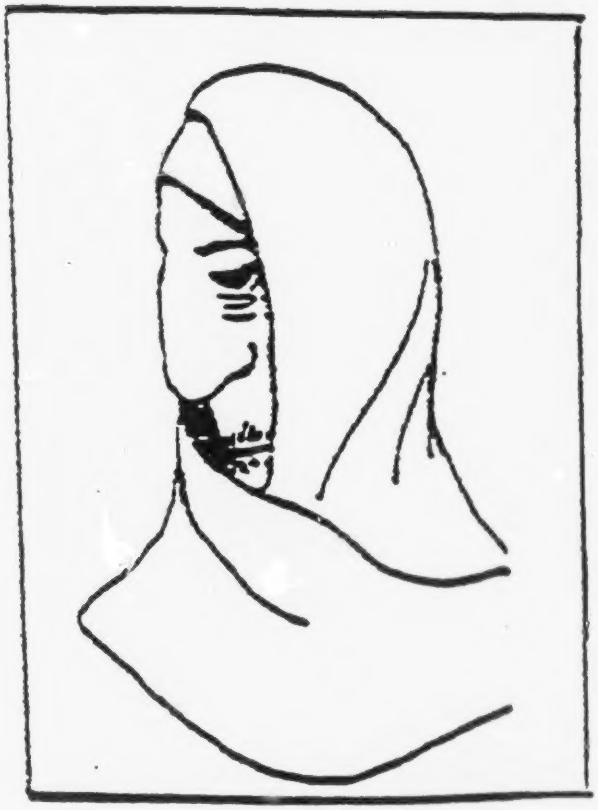


Adapted with permission from
Resource Mothers, 1993.

The "young woman" in the picture

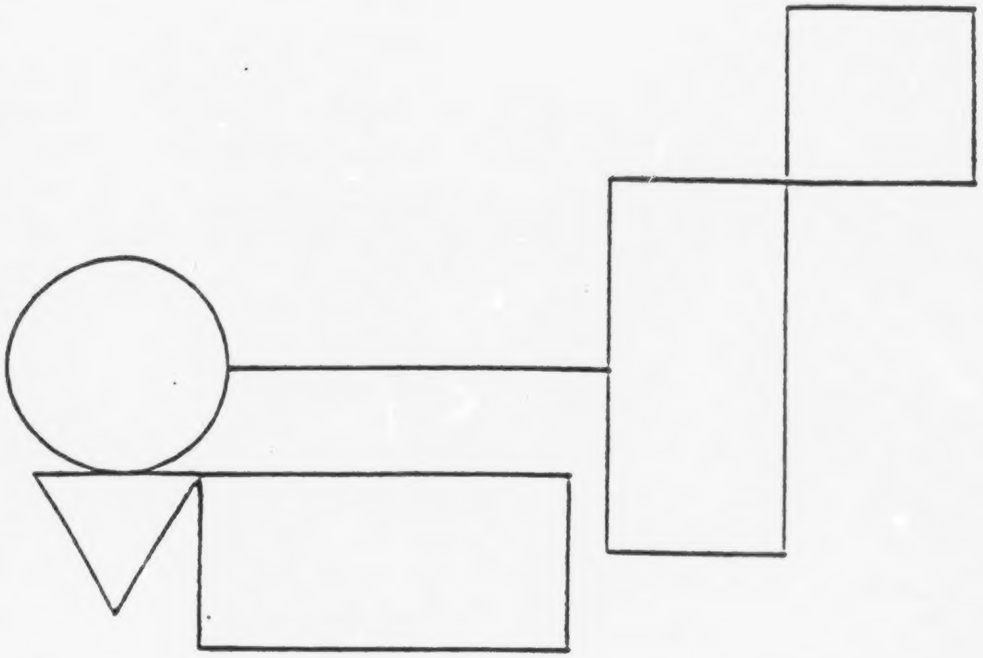


The "old woman" in the picture



Adapted with permission from
Resource Mothers, 1993.

IMPORTANCE OF FEEDBACK/GEOMETRIC PATTERN



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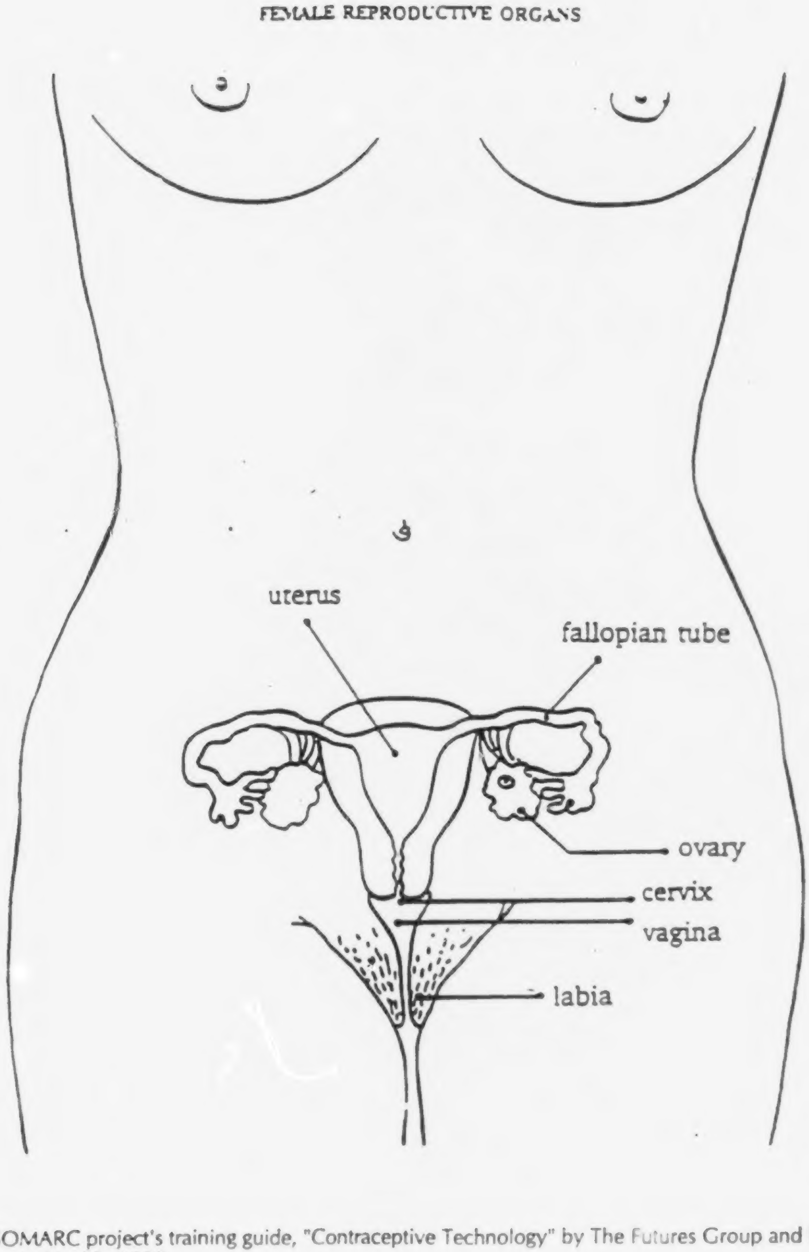
FEMALE REPRODUCTIVE ORGANS


FEMALE REPRODUCTIVE ORGANS
uterus
fallopian tube
ovary
cervix
vagina
labia

From the SOMARC project's training guide, "Contraceptive Technology" by The Futures Group and Program for Appropriate Technology in Health, 1990.

USING SIMPLE WORDS

Instructions: Put up these sentences on an overhead one sentence at a time. Read a sentence to the group. Ask people to rephrase it. Encourage people to use notes to help remember the new statements. Ask for people to say how they had rephrased things. [A sample of each rephrased statement follows if people have difficulty.]

1. **I think Tanya really needs medical attention for this chronic inflammation around her eyes.**

   [I think Tanya really needs to be seen by a doctor because this eye problem – or infection – keeps coming back.]

2. **This skin rash is not resolving – have you asked your physician for a referral to a pediatric dermatologist?**

   [This skin rash is not going away. Have you talked to your doctor about going to a skin doctor who specializes in babies and children?]

3. **Approximately 72 hours after delivery, the breasts engorge.**

   [About 3 days after the baby is born, the breasts fill with milk.]

4. **Parental discipline techniques vary and some resort to physical punishment.**

   [Parents try different ways to discipline their children. Some parents spank or punish their children physically.]

5. **Many children learn to verbally express themselves in a limited way even before 12 months of age.**

   [Many children learn to say a few baby words before their first birthday.]

6. **Exploration is essential for learning in infancy.**

   [Babies need to explore things and touch things in order to learn.]

7. **This toy is designed to be developmentally appropriate for your child.**

   [This toy is especially good for ___ month old babies like Tanya who are just now ready to do _____, _____ and _____.]

8. **This helps your child develop emotionally, socially and cognitively.**

   [This helps your child develop and learn about feelings, other people and new things.]

PRACTICE ROLE PLAY SITUATIONS

Instructions: Show role play only to person playing the mother. Put role plays on cards to be picked randomly.

1. This is your second pregnancy. Your first child was born three years ago, but was put into foster care when you were busted for possession of cocaine. You are bitter about this experience, and extremely suspicious of Mrs. P.S.S. You figure Mrs. P.S.S. is planning to snatch away your new baby as soon as it's born. You tell Mrs. P.S.S.: "I only signed up for this program because I thought you could help me get my other child back. But that doesn't mean I like people like you snooping around here and telling me how to live my life, or interfering with my baby." What could the PSS say to try to establish some rapport?

2. You arrived at your client's apartment to find her locking the door on her way out. She seems upset, and not happy to see you. You try to find out what's wrong, and she keeps putting you off, saying that she has to get going. You notice some bruises on her face, and what looks like a black eye is starting to swell up. What could the PSS say to her?

3. You visit a client who lives at home with her mother. The mother lets you in, and immediately says to you, "I want you to tell my daughter to stay out of trouble. I tell you, I've had my hands full with her and her boyfriends tramping in and out at all hours!" The daughter starts yelling at her mother to shut up, and they begin quarreling about the daughter's behavior and boyfriends, and the mother's busybody attitude. Both appeal to you to take their side. What could the PSS do?

4. When you visit your client, you sense that something is bothering her. After some hesitation, she tells you that this is her father's house and her father has been helping her out with expenses ever since her boyfriend left, but he's threatening to stop giving her any money unless she gives the baby up for adoption and gets a job. He wants her to "get her life in order." If she obeys her father, she won't be able to keep her baby. But if she refuses to do what he asks, she might be forced to move out. She won't be able to afford rent and groceries on her own. How does the PSS begin counseling her, and work to gain her trust?

5. You are a heavy smoker, you quit while you were pregnant but have started again. What could the PSS say?

6. You are pleasant and will do what ever the PSS. But you are being very spacy – handle the baby carelessly with support, you know nothing about infant care. You step out of the room to use coke secretly while the visitor is there. What could the PSS do?

7. You are very sweet; very over protective; you had a previous baby die of SIDS. You won't let anyone else touch or hold the baby – including your husband. You never let the baby out of your sight, even at night. Your husband has become upset of all of this. What could the PSS do to support both the mother and father?

8. You have 2 children under 5 in addition to the current baby. You are very concerned because you are pregnant again. You think you'll be thrown out of the program. You voice initially that abortion is "bad" but request more information about it by the end of the interview. What could the PSS do?

9. You have another child – age 7. You are used to working and are unhappy that you are home with the kids – you want to get back to work. You want to make it clear that you have always supported yourself. During the discussion, you are extremely verbally abusive to the 7 year old – but talk about never hitting her. What could the PSS do?

10. Mother brags about all the baby things she has "in the other room" (if fact, she has nothing). She is out of formula and has been watering down formula for several days. Mother has no friends or family in the area and is very isolated – but is embarrassed to say so at first. What could the PSS do to address the immediate needs and begin on longer term needs?

5 STEPS TO CHANGE BEHAVIOR

1. Know what to do and how to do it.
2. Believe it can be done.
3. Try it once.
4. Get reinforcement.
5. Continue to do it.

VALUES CLARIFICATION SHEET

Directions: First read each statement. When you are finished, review the list again and select the value which is most important to you. Write a "1" next to it. Write a "2" next to the value that is second in importance to you and "3" next to the value that is third in importance to you. Continue in this manner until you have ranked the six items which are of greatest importance to you.

Health ________

Money ________

Sound mind ________

Safe home ________

Opportunity to learn ________

Clean environment ________

Marriage ________

Children ________

Success ________

Happiness ________

Spirituality ________

Friends ________

Citizenship ________

Taking care of my family needs ________

Good food ________

Having a man around the house ________

Being liked by others ________

Being able to do whatever I want ________

Pride ________

Adapted with permission from
Resource Mothers, 1993.

USING SIMPLE WORDS

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USING SIMPLE WORDS

Get in the habit of using simple words in your daily work with mothers. Resist using the jargon that you will learn and hear as you work on this project. Learn words doctors use so you can act as a translator for mothers.

The glossary in the Resource Mothers Guide has simple definitions of many terms you will need to know.

For example, in your everyday work:

Say: "Be checked by the doctor" NOT "needs medical attention"

Say: "doctor" NOT "physician"

Say: "doctor or nurse" NOT "healthcare provider" or "clinician"

Say: "when the baby needs to get immunizations" NOT "the immunization schedule"

Say: "how you will pay the bill" NOT "method of payment"

Say: "diseases you get through sex" NOT "sexually transmitted diseases"

Say: "a kind of contraception or birth control" NOT "contraceptive method"

Say: "to see how the baby is learning and growing" NOT "conduct a developmental assessment

Adapted with permission from Resource Mothers, 1993.

MAKING SURE INFORMATION IS CLEAR

To make sure your information is clear:

- ✓ Use short words and short sentences.
- ✓ Use words that your clients understand.
- ✓ Use pictures and print materials if available.
- ✓ Show samples or examples, a rectal thermometer, or different contraceptives to the client.
- ✓ Stop from time to time and ask clients if they understand.
- ✓ Ask if they have questions.
- ✓ Repeat instructions – or main messages.
- ✓ Ask clients to repeat instructions and/or these main messages. Then you will know if they understand.

Adapted with permission from Resource Mothers, 1993.

TIPS ON WORKING WITH LOW LITERATE FAMILIES

Print. Use upper and lower case letters.

Use simple words and sentences. If you need to write difficult words, point to the words and say them.

Use pictures whenever possible.

Use space to simplify messages.

AVOID:

Abbreviations (B.I.D., TBS, QD).

Graphs.

Contractions.

Bullets (difficult to follow through).

2 or 3 syllable words.

GUIDELINES FOR WRITING FOR A LOW LITERATE POPULATION
DO'S AND DON'TS

DO THESE THINGS:

Use short words people know.
Start with the action word that tells people what to do.
In lists with bullets, specify on each line what to do.
Construct sentences to avoid adding "ing", "tion", "ed" or "s".
Break up long sentences.
Start a new sentence on a new line.
Repeat the subject of the sentence instead of relying on "it, they, he, she, those, these, this."
Limit punctuation to periods and commas.
Use white spaces. Keep things simple.
Print neatly. Form your letters traditionally.
Use upper and lower case letters.
Use an easy-to-read font.
Underline words instead of making them bold.

DO NOT DO THESE THINGS:

Do not use abbreviations.
Do not use parenthesis (people think you should skip anything in them).
Do not use contractions.
Do not use colons, semi-colons, slashes or quotation marks.
Type hyphens out of hyphenated words (follow up visit).
Do not split words at the end of a line of text.
Avoid long words and words with silent letters.
Do not use graphs.

SPEND TIME ON IMPORTANT TERMS THAT HAVE NO SUBSTITUTES

Point to the word as you say it.
Acknowledge that it isn't written the way it sounds.
Use a picture.
Give more familiar term first.
    Some people call this Intal.
    Some people call it Cromolyn.
Write the word again the way you say it.
    Theophylline. You say it like this: Thee-off-a-lin

COMMUNICATION

RESPECT is the ability to treat another person with dignity and with a feeling that he or she is worthy of being understood.

GENUINENESS is the ability to convey sincerity in both words and actions.

EMPATHY is the ability to put oneself "in another person's shoes", to view an experience from that person's perspective.

TYPES OF QUESTIONS

	Close-Ended Questions	Open-Ended Questions	Probing Questions	Leading Questions
When to Use:	Begin with close-ended question (for example, a question used in taking a medical history)	Continues with an open-ended question.	Then use a probing question in response to a reply, as a request for further information. NOTE: Out of context, probing questions may sound leading.	AVOID USING LEADING QUESTIONS.
Require:	Brief and exact reply; often elicits yes or no response.	Longer reply; demands thought, allows for explanation of feelings and concerns.	Explanation of an earlier statement.	Leads respondents to answer the question in a particular way or tells them about something that they might not otherwise have thought of.
Example:	How many children do you have? How old is your daughter?	What do you think about breastfeeding your new baby? How have you cared for her when she has had diarrhea in the past?	Why do you think it is difficult to breastfeed? Why can't she have anything to drink when she suffers from diarrhea?	Don't all good mothers breastfeed their babies? Isn't giving an IV solution the best treatment for a child with diarrhea?
Other Examples:				

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LISTENING SKILLS SELF ASSESSMENT

As a listener, do you ever find yourself engaging in these listening habits? Check the column that best fits what you do.

LISTENING HABITS					
	Almost Always	Usually	Sometimes	Seldom	Almost Never
1. Interrupting the speaker.					
2. Getting easily distracted by a voice too loud, too soft, poor grammar, muttering, etc.					
3. Paying attention only when you find the topic interesting.					
4. Judging everything the speaker says as "right" or "wrong".					
5. Doing something else while listening (e.g. doing paperwork, talking to someone else, etc.)					
6. Pretending you are paying attention to the speaker when you are actually ignoring his remarks and thinking of other things.					
7. Interested only in expressing your own ideas and not caring about what other person has to say.					
8. Daydreaming when speaker talks too slowly.					
9. Listening mainly for information you can use against the speaker.					
10. Thinking about what you are going to do or say rather than focusing on what the speaker is saying.					

Adapted with permission from Resource Mothers, 1993.

INAPPROPRIATE RESPONSES

A. **Irrelevant Response.** It bears no relationship or relevance to what has been said. Thus, it ignores the "sender" entirely. Example:

Person A: My boyfriend won't let me visit my cousin in San...
Person B: Hey, Chuck starts a new job tomorrow.

B. **Changing the Subject.** This response suggests acknowledgement of what the other person was saying but changes the subject. Example:

Person A: My boyfriend won't let me visit my cousin in San Francisco.
Person B: Well, boyfriends are like that. Hey, Chuck starts a new job tomorrow.

C. **Incongruous Response.** This occurs when a nonverbal message appears to conflict with the verbal message. Example.

Person A: We really accomplished a lot by doing these exercises.
Person B: (Rolling her eyes and looking bored) Yes, I sure learned a lot.

D. **Interrupting the Speaker.** Interruptions means that the listener breaks in before the other person has finished a statement. This can happen because: 1) she believes what she has to say is superior to what the other person is saying; 2) she believes she knows what the other person is going to say and she wants the other person to realize she already knows; 3) she is not paying careful attention; 4) she is excited by what the speaker is saying and wants to hurry the conversation along. Example:

Person A: I'm worried about the way my boyfriend...
Person B: I see... your boyfriend is really temperamental, but I don't think that's a big problem.

Adapted with permission from Resource Mothers, 1993.

CAREFUL LISTENING AND LEARNING: GUIDELINES FOR PARENTING SUPPORT SPECIALISTS

When first meeting with a client, an effective Parenting Support Specialist listens as much as possible. If the PSS learns what a client's concerns are, it is easier to address them. If she understands the client's home and work or school situations well, it is easier to help her to make decisions regarding the problems she faces.

The following are some easy guidelines on careful listening and learning for Parenting Support Specialists:

- ✓ Find out what the client does and does not know about any topic or behavior under discussion and how she feels about it.
- ✓ Ask questions that allow clients to inform the PSS about their clients' needs and wants.
- ✓ Try not to ask questions that can be answered with "yes" or "no". The PSS should ask questions which make the client say what they need in their own words (these are called "open-ended questions"). Questions that start with "Why?" or "How?" are often good open-ended questions.
- ✓ PSS' should not always accept the first answers that people give them. If clients say things that indicate that they are thinking of something else, the PSS should ask the same question in different ways. PSS' should always be polite and friendly so that the clients feel relaxed and trusting.
- ✓ If clients seem to feel uneasy when talking about any kind of abuse, family planning, or any other health topic, the PSS should talk about something else for a while, then gently return to the subject.

Adapted with permission from
Resource Mothers, 1993.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

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Resource Mothers, 1993.

POST-UNIT EVALUATION

UNIT COVERED: _______

DATE____________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? ______ If not, please explain.

Adapted with permission from
Resource Mothers, 1993.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

Adapted with permission from Resource Mothers, 1993.

POST-UNIT TEST

1. List three things you can do with body language to convey to a woman that you are paying attention and listening to her.

   1. ________________________________

   2. ________________________________

   3. ________________________________

2. Give examples of what your first comments might be to encourage and praise a mother and get her to talk more:

   Mother: "I'll just get to the clinic when I can. I never vaccinated my other children on time either."

   You say: ________________________________

   ____

   Mother: I'm just too tired to do anything about all these stupid safety things around the apartment that people keep talking about."

   You say: ________________________________

   ____

3. Change these close-ended questions to open-ended questions or statements that cannot be answered with a yes or a no.

   1. Are you having problems with the older children? ________________

   ____

   2. Is there someone you can call when you need a break? ________________

   ____

   3. Have you had a bad experience trying to take a baby's temperature rectally? ________

   ____

   ____

Adapted with permission from
Resource Mothers, 1993.

Unit 3

COPING WITH STRESS: PROBLEM-SOLVING AND DECISION-MAKING

Parenting Support Specialists help their clients improve their problem-solving and decision-making abilities. Effective problem-solving enables people to cope with some of the major stresses of everyday living. In this session participants will use communication and relationship-building skills and apply them to a problem-solving model adapted from Dr. Barbara Wasik, a clinical psychologist, who has worked with parents and home visitors.

Objectives

By the end of this unit, participants will be able to:

- Describe situations that can lead to stress.
- Discuss at least three things a person can do to reduce stress.
- Demonstrate ways of helping clients cope with the stress they experience due to the added demands of the birth of a baby.
- Demonstrate ways to get a client to discuss her perception of a problem or need.
- Describe why and how goal-setting and decision-making can empower clients.
- Demonstrate the use of one problem-solving plan, the 4 Step STAR Program. Adapted from Wasik, B. Coping With Parenting Through Effective Problem Solving (Ch. 3, pp. 16-22).
- Explain the physical and emotional responses to stress.
- Recognize appropriate use of supervision.
- Explain the benefits of effective time management through prioritization.
- Guide a relaxation induction exercise or other stress reduction technique.

Time

12 hours

Outline

A. Introduction/Definitions
B. Living With Stress
C. Identifying and Solving Problems - STAR 4 Step Problem Solving
D. How Decision-Making Affects Empowerment
E. Problem-Solving Practice Session
F. Practice Time Management Techniques Through a Scheduling Exercise
G. Practice Relaxation Induction Exercises
H. Summary and Review

Materials

- Resource Mothers. (1993). Handbook. Sterling, VA: INMED.
- Conceptual Paradigm **(Handout #1)**.
- Identifying Your Stress Signals and Reactions **(Handout #2)**.
- Coping With Stress **(Training Aid #1)**.
- STAR Problem-Solving Process, **Training Aid #2/Handout #4**.
- Toward a Healthier Lifestyle **(Handout #3)**.

Adapted with permission from Resource Mothers, 1993.

- Practice Role Play Situations (**Handout #5**).
- Weekly Activities (**Handout #6**).
- PSS Weekly Schedule (**Training Aid #3**).
- Role Play Feedback (**Overhead #1**).
- Post-Unit Evaluation.
- Newsprint, markers, tape, or blackboard and chalk.
- Video Equipment: video camera, tripod, tape, VCR, and television
- Post-Unit Test

Advance Preparation:

- Read the *Resource Mothers Handbook*, Chapter 3, "A Problem-Solving Approach to Helping Clients Deal With Stress."
- Ask PSS to read Chapter 3 of their *Handbook* prior to the session.
- Make sufficient copies of any handouts.
- Make any necessary transparencies.
- Try out video equipment. Set up camera to videotape role plays.

Adapted with permission from
Resource Mothers, 1993.

A. INTRODUCTION/DEFINITIONS (½ hour)

Rationale: The purpose of this unit is to develop a problem-solving approach that will help Parenting Support Specialists to help their clients (and/or their families) make decisions by identifying concerns and goals, setting priorities, and developing a plan for carrying out proposed solutions.

Procedure: 1. **Discussion**. Some of the main points to cover in this introduction follow: Introduction of Pride in Parenting Conceptual Paradigm **(Handout #1)**.

✓ Explain this conceptual model from the standpoint of daily life and how it is integral to the PIP study.

✓ Many of the decisions we make are easy, others are more complicated. Ask the group what decisions they have made today. **Possible responses** might be: what to eat for breakfast, what to wear, whether to read the paper or watch TV, whether to drive or take the bus to this training, etc.

✓ Problem-solving serves to reduce stress and promote a sense of well-being and personal strength. Solving a problem involves making a decision. We may think about taking some action for a long time or we may just instinctively do it. The key role for the PSS is "to help" her client make her own decisions, as opposed to doing something for her.

2. Present the following - or similar - scenario for discussion: A PSS goes to a client's home. The client, mother of three week old James, immediately tells her she hasn't been able to sleep for the past two nights and she is exhausted. The PSS says to the client, "The same thing happened to me last week. Here's what you do: heat up a glass of milk and add two teaspoons of honey. Come on, I'll make some for you." The client does what the PSS advised and it works. She sleeps soundly and is pleased.

What happened here? Is the problem solved? Discuss. Did the PSS help her client solve a problem? **Possible responses** might be:

- Clients in our program are expected to be active participants.
- Parenting Support Specialists should promote a more collaborative, partnership-like relationship between themselves and their clients.
- The role of the PSS is to promote self-sufficiency and independence.
- Our program will encourage clients to define their own needs and set preferences for services they wish to receive.
- The PSS's role is not to be the "expert," but rather, the person who helps the client recognize her own strengths in order to solve her own problems and make decisions.

Adapted with permission from Resource Mothers, 1993.

Try to elicit from the trainees that solving a client's problem for her may help alleviate present stress, but it will not give her the tools she needs to be able to deal with future stress. On the other hand, what did happen in the incident described that might be of benefit?

Point out that by using the problem- solving model, Parenting Support Specialists can "model" for the client - and others in their lives - ways to "think through" problems and carry out plans.

B. LIVING WITH STRESS (2-1/2 hours)

Rationale: Stress is a part of everyday life. Stress can have both positive and negative effects on people. Recognizing stress is the first step in dealing with its effects.

Procedure: 1. Distribute **Handout #2**, Identifying Your Stress Signals and Reactions. Give trainees 5 minutes to fill out this one page summary of reactions to stressful situations and possible ways of coping. Tell them you will discuss their reactions in a few minutes. As an alternative, read each item, one at a time, with trainees and discuss their answers together.

2. Point out that Chapter 3 of the *Resource Mothers Handbook* contains information about stress, including positive and negative reactions to stress, and ways of coping with stress. You might summarize with some of the following.

✓ Stress refers to emotional or mental strain or tension. We all experience stress every day, because our lives are stressful. Stress often develops from having: too much responsibility or information; too many emotional concerns; an inability to remedy a bad situation; or, too many changes. Stress is a response to situations that may frighten, excite, worry, confuse, endanger, or irritate. There are different kinds of stress. Three common types are:

- *Ordinary*: Examples might include: waking up; getting to work on time;
- *Developmental*: Examples might include: learning a new skill; taking on a new challenge or responsibility.
- *Unique*: Examples might include: unintended pregnancy; abusive partner; and, dangerous living situations.

Ask trainees for additional examples of each from their own experiences.

3. Ask if stress is good or bad and have trainees give reasons for their opinions. **Possible responses** might include:

Good:

- Can give a person extra momentum; can actually improve a person's performance at work or home.
- Positive stress can be exciting; help a person gain extra energy to meet challenges.

Bad:

- Can make a person feel irritable, anxious, tired, and depressed. Any of these feelings can cause a drop in a person's energy level, and may cause her to be overly harsh with family, friends, or co-workers.
- Can weaken and disturb the body's defense mechanisms, so a stressed out person is more prone to illness.
- If unrelieved, stress can cause both physical and emotional harm to a person's body.
- May play a role in development of ulcers, heart disease, high blood pressure, and migraine headaches.
- Can affect children or other family members.

4. Discuss the fact that stress is different for different people. What is stressful to you may not be stressful to your neighbor. Life events - such as a marriage, divorce, or a child leaving home - can cause stress and can be either a time of negative or positive change. Positive stress can become negative stress when a challenge becomes long term or when problems persist and are not solved.

5. Suggest that participants discuss some of the "stressors" in their lives. What are some of the stresses of parenting? Of starting a new job? Do they anticipate any stresses when they are out in the community working with clients? **(Handout #2)**

6. Discuss stress following delivery of a newborn. Point out that even though this can be a very special time for a woman and her family, it can also be a time of added stress. A few points you may want to cover:

✓ Change is one of the biggest causes of stress, and having a baby is certainly a time of change. There are changes in a woman's body, changes in the way women see themselves and the way others see them, and perhaps changes in their situation at home and/or work. Childbirth adds a whole new set of stress. Many women undergo enormous emotional changes as they worry about the responsibilities of parenthood. This can be particularly true if the woman is very young, unmarried, still a child herself, and/or didn't actually plan to get pregnant and become a mother at this time.

✓ Shifts in hormone levels following pregnancy may be responsible for mood swings and may make it more difficult for a woman to cope with the daily stresses in her life.

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✓ If the stress is not relieved, and if it is allowed to build up, a woman becomes more susceptible to health problems. Women who react to stress by reaching for a cigarette, a beer, a "joint," or crack cocaine to relieve their tension or anxiety, increase the risk of having a baby being born sickly or with birth defects or may be unable to adequately care for a newborn. Some studies indicate that extreme psychological stress may cause a woman to give birth to a low birthweight baby.

✓ Let trainees know that if they see (or feel) that any client is overwhelmed by stress at any time, they should make sure she sees her health care provider right away.

7. Share with the group: There are 3 basic ways people generally cope with stress:

- Acting out
- Withdrawal
- Taking charge

Ask for trainees' comments. Ask them for examples of each, from their own experiences, or from what they've observed others do.

8. **Activity.** Ask trainees to develop a list of "stress relievers" - any activities they have tried that have helped them reduce stress. You can do this as a group or ask individuals to do this alone. Allow them 5-10 minutes to complete the task.

Discuss their stress relieving activities, and why they think these activities worked. Which activities would they be most likely to recommend to new mothers? Why? Ask if anyone else tried some of these activities and found they didn't work. Which ones? Any ideas as to why they weren't helpful in relieving stress? Make a master list on newsprint and develop a list for them to use when making home visits.

Distribute **Handout #3,** Toward A Healthier Lifestyle. Use this handout to discuss, in some detail, stress relievers such as exercise, relaxation, and the role of diet, hobbies, and recreation in stress reduction. Then review the coping skills outlined in this handout. A discussion of these coping skills can serve as a good lead to the next section on "Identifying and Solving Problems."

9. **Activity.** Use **Training Aid #1** which gives a brief scenario followed by a series of discussion questions. Use these questions as points of discussion. As with any case study scenario, you can process this in any way you choose. Some alternatives: 1) Read the scenario to the group, and then raise the issues found in items A to F and let the group discuss. (If you use this methodology, it sometimes helps to have someone note key ideas on the chalkboard.) 2) Distribute the case study, ask trainees to read the page and then discuss the issues, either as a group, or with a

partner. (If you select this approach, the training aid actually becomes a handout, and a copy for each participant will need to be made before the session.)

As facilitator, make sure everyone is heard from, and that all ideas are encouraged.

C. IDENTIFYING AND SOLVING PROBLEMS (2 hours)

Rationale: One of the goals of our Parenting Support Specialists is to help clients deal with the stress they encounter as a result of the added responsibility of the birth of a baby. The problem-solving model selected for use in this program is adapted from work by Dr. Barbara Wasik.

Procedure: 1. Assure trainees that, before this training ends, they will have the skills necessary to help their clients solve their own problems and make decisions that seem "right" for them. The procedure they will follow is a four-step model designed to help people learn to cope effectively with personal problems in their everyday lives. Each step is an important part of the total problem-solving process.

2. Tell trainees they first will practice using this model to solve some of their own problems. Once they are comfortable using the model, they will be able to explain the process to their clients and "walk" them through it, step-by-step. As Parenting Support Specialists use this model with clients, they will be transferring problem-solving skills that will help their clients reduce stress in their lives.

This problem-solving model has been used successfully with diverse populations, both with "everyday" problems as well as "special needs" problems such as families affected by drug and alcohol, single parents, teen parents, depressed pregnant and parenting women, and parents of handicapped children.

3. Teaching Parenting Support Specialists to use the 4-step Problem-Solving for Parents Model will help them with their own problems and help them to help their clients. Discuss the following points as background information. It will set the stage for working to solve problems and make decisions.

- ✓ PSS' have to make decisions and deal with problems every day.
- ✓ For most problems, PSS' can learn to do something to make the problem situation better.
- ✓ A few problems may be ones PSS' cannot change, but have to learn to live with.

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- ✓ Confronting and dealing with problems usually ends up making their lives more pleasant. PSS' will also feel more confident of their abilities to solve problems in the future.
- ✓ PSS' will usually solve problems better if they think about them first before doing something about them.

4. Ask someone to volunteer one problem she had to deal with this week or that she tried to help someone else deal with this week. Teaching PSS' to use the 4-step problem-solving model will help them with their own problems **(Training Aid #2/Handout #4)**. Point out that although these steps are numbered consecutively, 1 through 4, actual problems are not always solved in this linear progression. With certain problems, the "problem-solver" may move back and forth among some of the steps. This is because problems and circumstances in their lives may change from day to day.

5. In solving a problem, a person has to answer questions and think through what she will do. Oftentimes there will be more than one option, and the option that first comes to one's mind may not be the best one. Go through each of the first 3 steps and make sure the steps and tasks are clear.

For example, if the problem posed by the participant who volunteered (see #5 of Trainer's Notes above) was "My clothes are all too tight and I have almost nothing to wear." As a group, look at the steps, talk about what to consider, and then have the group discuss possible answers. In this case the problem could be "I'm gaining too much weight," but it could be that the person is putting all her clothes in the laundromat dryer and they are shrinking. So first you must agree on precisely what is the problem or concern.

Then move on to the next step and again, as a group activity, discuss what the woman wants to have happen. They will probably agree to a goal such as "I want all my clothes to fit well so I feel comfortable." Continue in this fashion through the first 3 steps.

By the time the group has finished discussing step 3, they will probably have come to a decision. What has to happen now? Answer: Some action must be taken. And if no action is taken, what happens? Will the problem get solved? Probably not. The 4th step in the process is responding or taking action. This step requires that a person do something. Thus, to properly solve a problem, a person has to do two things. What are they? **Expected response:**

- **Think** about the problem and then act.

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What happens after the person acts? She must ask herself if she solved the problem. Did her action work? If not, she again needs to think about why not, and what else she needs to do.

6. Review key points.

- Stop, Think, Ask, Respond, and Check-STAR

Discuss: Why is it important to stop? Where is a good place to think? Sitting quietly? Walking to work? Any place? Why? Why is it important to ask ourselves what might happen with each choice? Why is it necessary to respond or act? And finally, what do we do to see how our plan worked?

7. **Team activity.** Begin this activity by sharing a problem and walk trainees through the process, as you would go about solving it. Example of possible problem:

"The day care provider called to say my baby Andy is sick and I should come get him. But our training session won't end for several hours and I know the Program Director is counting on me to stick to the schedule."

Then ask each trainee to write down three problems that she encountered within the last week or two. Next, have everyone pick a partner. Together, they should select one of the problems one of them jotted down, and discuss how they should go about solving it. They should be sure to cover all four steps, including what action is going to be taken. Ask the person who presented the problem if this is the same decision that was reached when the problem actually arose. If not, why might this decision be different? Was it because they took time to consider different alternatives before rushing into a decision?

When the teams finish, they should pick one of the "real life" problems encountered by the other team member. Repeat the same procedure.

8. Bring the group back together and process what went on. Ask someone to describe how it felt to use this problem-solving process. Do they think it is possible to use this process and still not solve their problem? Discuss reasons why or why not. Point out that many people don't like to make decisions.

Sometimes people think that if they just ignore a problem, or pretend it doesn't exist, it will just go away. Is this realistic? Why or why not? Making a decision lets you decide about your life. Thinking about the decision helps you focus on what is important to you. And any decision you make should be **yours,** and not something that someone else decided for you. Everyone is unique (as discussed in Unit 2), and each must consider the consequences of decisions and actions in terms of individual values and priorities, and what is believed to be best in any given situation.

9. Explain that as soon as trainees feel comfortable using this problem-solving model to solve their own problems, they will be ready to transfer this process to their clients. (Tell them it also works with relatives and friends.) As PSS' help their clients use this approach for problem-solving and decision-making, they will notice that it helps clients gain power and control over their lives.

10. Make sure everyone's questions are answered and comments heard before moving on.

D. HOW DECISION-MAKING AFFECTS EMPOWERMENT (3/4 hour)

Rationale: Being able to make decisions, take action, and accept responsibility for actions is an enabling process. PSS' can help empower clients by helping them define goals, make decisions and take action.

Procedure: 1. Ask trainees to take out a piece of paper. Ask them to jot down whatever comes into their mind when they hear the word **"empowerment"** or the action form of this word, **"empowering."** They should try to define what these words mean to them, and also give examples - from their own lives or from the experience of someone they know - of things they have done that have given them a sense of empowerment. They may want to reflect back to their River of Life (Unit 1). This is not a test and you won't collect their papers. Allow about 10 minutes.

2. Ask for a volunteer to share her definition of empowerment. Write key points on newsprint or the chalkboard. Ask others to add to this definition. After each person has contributed, work as a group to compose a workable definition of empowerment. It might look something like this:

- A feeling of self-worth and self-confidence that allows people to define their own goals and make good decisions and choices for themselves.

3. Next ask the trainees to share the experiences they noted on their papers that led to a feeling of empowerment. Encourage everyone to contribute. Base your "processing" of their comments on what trainees had to say. For example, did more than one participant have a similar example? If so, was this strictly coincidental? Or might there be other reasons? Discuss these reasons. If not exactly alike, do the examples have a common thread? (The group will probably find that many examples have to do with asserting themselves, making a decision and then

following through with an action, and then feeling good about themselves when they achieved the result they wanted.)

4. Discuss with trainees why being a "helper" is a challenge, but also a real opportunity: to help clients take control of their own lives. As PSS' help clients confront and then work to solve their problems, they will help women feel better about themselves. This will happen – gradually, to be sure – as clients gain confidence in their ability to make choices that are right for them.

5. Before moving on, make sure everyone understands this close relationship between decision-making (and problem- solving; the two terms are so closely related) and empowerment. In the next unit, **"Helping Clients Build Self-Esteem and Deal With Feelings,"** the idea of empowerment is further explored.

E. PROBLEM-SOLVING PRACTICE SESSION (1 hour)

Rationale: Participants must decide how they will help their clients cope with stress by working to address and solve their clients' problems. The sooner PSS' become comfortable with this model, the more likely they are to use it when making home visits.

Procedure: 1. **Activity.** Consult **Handout #5** which contains some practice role play situations. Ask each trainee to select a partner with whom to work. Assign each one a role play scenario. Although eventually the teams will act out their scenarios, tell participants that they should first discuss the problem situation with their teammate and outline how they will go about working through the problem-solving process. Suggest they may even want to jot down some notes to better remember their game plan. Then they are ready to role play a home visit.

2. Depending on the size of your training program and the number of new scenarios created for the program, you may want to distribute the same role play scenario to each team, or assign different ones simultaneously. Allow enough time so that each trainee gets to "play" her own role in 2 to 3 different scenarios, and more if your observations indicate participants need more practice.

3. As the teams are working, move among the groups so you can observe/hear what's going on. It's okay to offer advice, but be sure to explain **the reason** for any suggestions given.

Adapted with permission from Resource Mothers, 1993.

F. PRACTICE TIME MANAGEMENT THROUGH A SCHEDULING EXERCISE (1 hour)

Rationale: Organizing the activities you are responsible for to make the most effective use of time is one way to reduce stress. Establishing a routine may also help assure that tasks get done on time.

Procedure: 1. Have members of the group offer examples of ways in which they have organized their schedule to be most efficient.

2. Have group participants talk about their own strategies for reminding themselves about what needs to be done.

3. Discuss some of the scheduling needs participants will need to consider in fulfilling their role as a PSS.

Activity. Have participants look over the list of activities described in **Handout #6**. Review the different approaches and perhaps decide on what would be effective for the team as a whole. Develop a tentative weekly schedule that could be used at each site. **(Training Aid #3).**

G. PRACTICE RELAXATION INDUCTION EXERCISES (3/4 hour)

Rationale: Relaxation training and meditation are two ways to deal with the physiological and emotional responses to stress.

Procedure: 1. Explain that a person can train herself to move into a relaxed physical state. Once a person has learned to do this, it can counteract states of stress and tension.

2. PSS's may themselves experience a great deal of stress in assisting the families in the project with their complex problems. Learning a relaxation exercise may help them deal with these reactions. They will also be able to pass on this technique to the mothers so that they too can reduce their stress by practicing a relaxation technique.

3. Teach the PSS's the relaxation procedure and allow practice time.

4. Some people find that meditation works for them in a similar way. Have PSS's describe any methods they have learned for producing a relaxed state.

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H. SUMMARY AND REVIEW (20 minutes)

Procedure: 1. Follow one of the procedures outlined in Units 1 or 2. Be sure to rotate, so it's not always the same participant who's summarizing the session. If you refer back to the objectives and re-word them as questions, then trainees can take turns responding.

2. Distribute and ask participants to complete a post-unit evaluation form. Remember that, if you later learn when reading these forms that certain topics were not well understood, you will want to modify your training program so as to re-emphasize any important material that remains unclear. This is one of the strengths of doing some kind of brief evaluation at the end of each unit: you still have the ability - and time - to alter your schedule. If you wait until the end of the entire training course to find out its weaknesses, it's usually too late to take any sort of compensatory action.

3. Distribute Post-Unit Test.

CONCEPTUAL PARADIGM

(Insert harvard graphics chart 5655-085.CH3)

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IDENTIFYING YOUR STRESS SIGNALS AND REACTIONS

How do you react to a stressful situation? (Mark all the signals or signs that apply)

_____ I worry.
_____ I become nervous.
_____ I get a headache.
_____ My heart pounds.
_____ I feel faint.
_____ I feel hot.
_____ My hands shake.
_____ I stutter or have difficulty talking.
_____ My face breaks out.
_____ I lose sleep.
_____ I feel my muscles tighten.
_____ My stomach hurts.
_____ My face becomes red.
_____ I feel cold.
_____ I feel like crying.
_____ I can't sit still.
_____ I cough or clear my throat.

What other reactions do you have? ____

____

How do you currently cope with your stress reactions?

_____ I get angry.
_____ I become depressed.
_____ I take medication (aspirin, tranquilizers, etc.)
_____ I drink or use illegally acquired drugs.
_____ I blame my problems on others.
_____ I tell myself that I'll laugh about this later.
_____ I ignore them.
_____ I talk about the stress with a friend, family member, or counselor.
_____ I look for ways to change the stress-causing situation.
_____ I hate myself.
_____ I laugh at the situation.
_____ I accept the situation.
_____ I think about suicide.
_____ I withdraw from others.
_____ I eat.
_____ I try to make others feel miserable, too.
_____ I try to think of a way to avoid this kind of stressful situation in the future.

What other ways do you have of coping with your stress reactions?

____

____

____

From: Wayne State University, Institute of Maternal and Child Health, "Maternal Child Health Advocate Training Program: Manual."

Adapted with permission from Resource Mothers, 1993.

TOWARD A HEALTHIER LIFESTYLE

ACTIVITIES WHICH STRENGTHEN THE BODY, MIND AND SPIRIT

• Exercise	Exercise works out stress. Stretching loosens stiff muscles so commonly associated with stress. Four helpful stretches include those that stretch the neck, back, calves, and shoulders.
• Diet	Eat balanced meals: plenty of fruits of vegetables; whole grains and breads; drink lots of water; and limit salts. Don't eat lots of caffeine, sugar or any alcohol during stressful periods.
• Relaxation	Deep breathing helps to relieve tension. It offsets the stress-reaction of shallow breathing. Inhale through the nose, pressing stomach outward. Hold your breath, then exhale through your mouth. Repeat several times.
• Quiet Time	Take a break each day to unwind. Start by reducing as many outside interruptions as possible. After finding a relaxing position, take deep breaths and visualize calm, peaceful situations. Five minutes of "quiet time" can rejuvenate you.
• Sleep	While conscious forms of relaxation are the most talked about, the merits of sleep often go unspoken. Sleep is the most natural stress-reliever. Get quality sleep. Don't take caffeine within four hours before bedtime; avoid naps; don't go to bed until you're sleepy; and don't exercise right before bedtime.

MEANINGFUL AND RELAXING DAILY ACTIVITIES

Activities which bring purpose and pleasure into our lives:

- ✓ Community involvement
- ✓ Hobbies and recreation
- ✓ Entertainment
- ✓ Visits with family and friends
- ✓ Prayer or meditation

Try to engage in at least one of these activities every day.

COPING SKILLS

Attitudes and behaviors which can help relieve stressful situations and prevent over-stress:

- Developing realistic attitudes and goals
- Communicating feelings
- Accepting yourself
- Being assertive
- Asking for what you need
- Building and using a support system
- Developing problem-solving skills
- Not rushing or worrying
- Planning ahead

Adapted from: Baby Love Maternal Outreach Project, NC Division of Maternal and Child Health, NC Division of Medical Assistance, Office of Rural Health and Resource Development, 1992.

Adapted with permission from Resource Mothers, 1993.

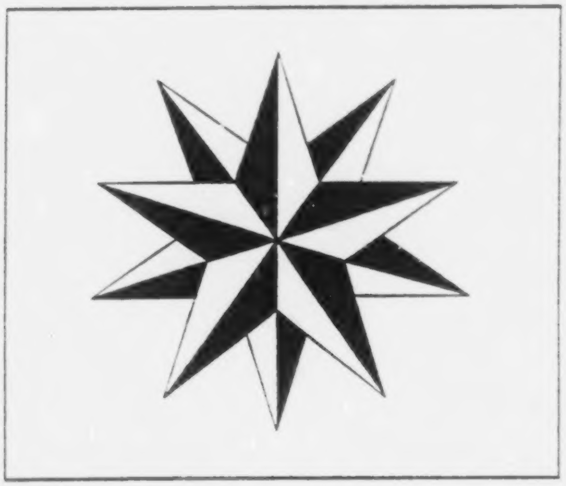
STAR PROBLEM-SOLVING PROCESS

S is for **Stop.** Stop and figure out what the problem is.

T is for **Think.** Think of all the possible ways to solve the problem.

A is for **Ask.** Ask yourself what would happen with each choice.

R is for **Respond.** Respond and make the best choice. Test it out.



From: "You Can Control Asthma" by Sue Schneider and M. Richard of Georgetown University; published by the Asthma and Allergy Foundation of America, Washington, D.C., 1994.

PRACTICE ROLE PLAY SITUATIONS

1. Your client is extremely upset and worried when you visit her. You discover that she has several overdue bills, and the collectors have been pestering her for payment. When she talks to her boyfriend, he tells her not to expect any money or help from him. You help her to write down her expenses. You and she are both surprised to discover how much money she spends each month just going to coffee shops, shopping malls, bars and fast-food restaurants. She is anxious to cut back on these expenses, but she asks you, "How will I get to see my friends anymore, if I stop going out to eat or shop? And I'll be so bored just sitting around at home with the baby!" How can you help her solve this immediate problem? Also what are some issues that you and she can discuss to perhaps bring about some changes in her lifestyle?

2. Your client had her baby about six months back, and she has been breastfeeding the baby ever since. She and her husband have not been using any family planning method. Now she is starting to wean her baby, and she has heard that the chances of getting pregnant again are really high at this time. She and her husband are fighting about this. She doesn't want another baby right away, but he refuses to use a condom and doesn't want her using any form of birth control either. She's scared to do anything behind his back, for fear of what he'd do if he found out. But the fear of getting pregnant again makes her tense and worried, and so neither of them is able to enjoy sex. Lately her husband has been hinting that he's not satisfied with their relationship, and he might just have to find someone else if she can't do right by him. How can you help her to work through this problem?

3. Your client has a boyfriend, Jim, who seems to be getting more and more violent and out-of-control. They both used to drink heavily, but lately she's been cutting back out of concern for her baby. She knows Jim started doing drugs a few months back, and now she's becoming more and more scared of him and his mood swings. Today when you visit her, you can tell that Jim recently gave her a beating. When you ask her how she's doing, she tells you that his violence is making her scared to live with him. "He doesn't know what he's doing when he's angry, and he could really hurt the baby when he gets that way," she says. When you mention the police and ask her what she thinks about calling them on drug or domestic violence charges, she says, "He'd really kill me if I did that!" How do you help her to reach some decisions in this situation?

4. Your client calls you from a pay phone in tears, and tells you that her mother wants her to move out of the house. You agree to meet your client at a fast-food restaurant, because the atmosphere at her home is very tense. She tells you that her mother's boyfriend made advances toward her. When she told her mother about it, the boyfriend denied it and her mother got really angry and told her to get out, and not to come back. She doesn't want to move out, but she's scared to be at home with her mother's boyfriend now. She also doesn't know how to ask her mother to let her stay, or to convince her that she is telling the truth. She's confused and upset, and doesn't know what her options are. How do you help her to tackle this problem.

5. Your client has not been feeling well. She is very fatigued, has no appetite, and has frequent diarrhea. She is very short-tempered with the kids and tells you she had to give the 4-year-old a whipping because he wet the bed he shares with her, 3 nights in a row. She keeps refusing to see a doctor, saying she hates visiting doctors and she can't afford to go. What are the important issues here that you and she can discuss and find some solutions?

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COPING WITH STRESS

1. A PSS comes into the office one morning. She looks tired and down. Her mother is ill with cancer. Yesterday she had to help a client get some food for her newborn and toddler and she worried about it all night. She didn't even want to come in to work today. When her supervisory asked for her work schedule for the day she snapped, "I don't have it yet. Why are you always picking on me?"

   A. What physical signs of stress does the PSS appear to have?

   ____
   ____
   ____

   B. What actions or feelings are shown by the PSS indicate that she is under stress?

   ____
   ____
   ____

   C. In this scenario, what appears to be a source of stress in this PSS's life?

   ____
   ____
   ____

   D. How can the PSS reduce her stress?

   ____
   ____
   ____

   E. How can the supervisor help the PSS reduce her stress?

   ____
   ____
   ____

   F. What can the PSS's co-workers do to help her reduce her stress?

   ____
   ____
   ____

From: Wayne State University, Institute of Maternal and Child Health, "Maternal and Child Health Advocate Training Program Manual."

WEEKLY ACTIVITIES

- Preparation for home visit - travel planning
- Preparation for home visit - curriculum review
- Home visit
- Family staffing (1 hour)
- Telephoning clients and schedule visits
- Telephone follow-up of clients and ongoing
- Finding resources
- Completing project forms
- Accompanying clients to resource agency
- Staff meeting (1 hour)

Adapted with permission from
Resource Mothers, 1993.

PSS WEEKLY SCHEDULE

DO NOT VISIT ON THE 1ST DAY OF THE MONTH

PSS WEEKLY PLAN

	Monday	Tuesday	Wednesday	Thursday	Friday
9:00-10:00am	Telephoning	Staffing			
10:00-11:00am	Home Visits	Home Visits			Home Visits
11:00-12:00pm		P-I Group (2nd and 4th week		P-I Group	
	Lunch	Lunch	Lunch	Lunch	Lunch
1:00-2:00pm					
2:00-3:00pm		Family Staffing		Team Staffing	
3:00-4:00pm	Preparation for visits and record keeping				
4:00-5:00pm	Telephoning				

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ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

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POST-UNIT EVALUATION

UNIT COVERED: ______

DATE__________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? ______ If not, please explain.

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5. In which skill areas do you feel you need more practice or help?

____

____

____

____

6. How can we make this unit better?

____

____

____

____

7. Any additional comments?

____

____

____

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POST UNIT TEST

1. List 5 sources of stress that you expect mothers in the project might experience?

    1. ______________________________
    2. ______________________________
    3. ______________________________
    4. ______________________________
    5. ______________________________

2. Describe 5 physical or emotional responses to stress.

    1. ______________________________
    2. ______________________________
    3. ______________________________
    4. ______________________________
    5. ______________________________

3. Describe 5 strategies for relieving stress.

    1. ______________________________
    2. ______________________________
    3. ______________________________
    4. ______________________________
    5. ______________________________

Adapted with permission from
Resource Mothers, 1993.

4. Describe the 4 steps of the STAR problem solving method.

   1. ______________________________
   2. ______________________________
   3. ______________________________
   4. ______________________________

5. Give 2 examples of someone demonstrating **empowerment.**

   1. ______________________________

   ____

   ____

   ____

   2. ______________________________

   ____

   ____

   ____

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Unit 4
HELPING CLIENTS BUILD SELF-ESTEEM AND DEAL WITH FEELINGS

Helping to build self-esteem is one way Parenting Support Specialists can empower their clients. Positive self-esteem can help individuals take charge of their lives and make choices and decisions. In addition, parents who possess self-esteem – who hold their own thoughts, beliefs and feelings in high regard – are more likely to pass those positive feelings of self-worth on to their children.

Objectives

By the end of this session, participants will be able to:

- Define self-esteem and its relationship to how a person makes choices and decisions.
- Describe the process of developing self-esteem.
- Demonstrate the role of praise and encouragement.
- Explain how a PSS's self-image influences her ability to build self-esteem in her clients.
- Provide tips to parents for building self-esteem in their children.
- Demonstrate positive and negative ways of dealing with anger (and/or other intense feelings).

Time

5-1/4 hours

Outline

A. Introduction/Self-Esteem
B. Helping Parents Build Their Children's Self-Esteem
C. Coping with Feelings
D. Handling Anger and Mishandling Anger
E. Responding to the Feelings of Others
F. Self-Acceptance
G. Summary and Review

Materials

- Resource Mothers. (1993). Handbook. Sterling, VA: INMED.
- Worksheet: What I Can Do to Build Self-Esteem **(Handout #1)**
- Giving Positive Messages **(Handout #2)**
- A Self-Assessment Tool: Strengths and Skills **(Handout #3)**
- Suggestions that Help to Encourage **(Handout #4)**
- Ways People Handle Anger **(Handout #5)**
- Self-Esteem Situations **(Training Aid #1)**
- Active Listening: Role Play **(Training Aid #2)**
- How I Feel About Myself: Issues to Consider **(Training Aid #3)**
- Role Play Feedback **(Overhead #1)**
- Post Unit Test
- Post Unit Evaluation
- Newsprint, markers, and tape or blackboard and chalk

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- Video Equipment: video camera, tripod, tape, VCR, and television

Advance Preparation:

- Read the *Resource Mothers Handbook,* Chapter 4, "Improving Self-Esteem."
- Assign this chapter as background reading to participants.
- A possible resource for PSS' to share with clients is the Channing L. Bete Co., Inc. booklets on self-esteem and peer pressure. These booklets use easy-to-read text augmented by many line drawings. Should you wish to give these to participants during training, they can be ordered by calling: 800-628-7733.
- Make sufficient copies of all handouts.
- Write out any information on newsprint that you will want to use during the unit, such as the list of points covered in **Training Aid #3** for use in the section on self-acceptance. Having information on newsprint makes it easier for trainees to recall what they are being asked to do.
- Should you wish more information on self-esteem, for a list of books and materials, call or write to B.L. Winch and Associates/Jalmar Press, 45 Hitching Post Drive, Building 2, Rolling Hills Estates, California, 90274-5169. Tel: 800-662-9662.
- Try out video equipment. Set up camera to videotape role plays.

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A. INTRODUCTION/SELF ESTEEM (2 hours)

Rationale: No one is born with self-esteem. It is learned, over time. People develop self-esteem as a result of how others react to them. This learning process begins in infancy as a baby learns that she or he is loved and valued. If a child believes she or he is not loved or that no one cares about her or him, then that child is likely to grow up believing she or he is not important. Being able to change feelings of low self-esteem is often a long, slow process. But it can happen.

Procedure: 1. **Group discussion.** Ask trainees what self-esteem means to them. Two related questions that can be part of this discussion are: How do we learn self-esteem? Why is self-esteem important? You will probably come up with a definition, to put on newsprint, that looks something like this:

✓ Self-esteem is a word used to describe how people feel about themselves. How people feel about themselves influences their actions towards others and what they accomplish in life.

Additional points that are appropriate to cover in this discussion include:

✓ If a teen or an adult does not believe in herself, it's hard for others to believe in that person. If a person thinks "I'm nobody," or "I don't matter," then it's predictable that he or she won't try to succeed at anything – not at school, not at work, not as a parent. And by not trying, he or she won't succeed, and his or her feelings of failure and rejection will become even stronger. It becomes difficult to break this cycle of failure.

✓ Feelings of self-esteem are not constant. They can change from day to day or from month to month. Positive experiences and fulfilling personal relationships help improve self-esteem. Negative experiences and troubled relationships can lower self-esteem.

✓ Everyone prefers to hear positive things said about them rather than negative things. Praise, encouragement, and reassurance are necessary ingredients in building self-esteem. But sometimes we are embarrassed. Why is this? Try to elicit cultural/social norms that make it difficult for us to take pride in ourselves. Discuss why it might be difficult for people in some cultures to accept praise, or to take pride in themselves.

2. **Distribute Handout #1**, What I Can Do to Build Self-Esteem. Ask trainees to concentrate only on the left hand side of this worksheet. Myself. Ask everyone to write down all the things that they can do to build up their self-esteem. Facilitate this exercise by asking each to think

about all the things that make them feel good about themselves including people or situations. Also ask trainees to reflect on things that made them feel bad. What have they done or can they do to overcome these negative things.

3. After about ten minutes, ask for volunteers to identify one easy thing that they can do to build their own self-esteem. After everyone has shared suggestions, ask for volunteers to share what kinds of things from their lists would be difficult to do in order to build their self-esteem. Why? Write all the ideas on newsprint.

4. Next, ask participants to think about what they can do to help clients improve their self-esteem. Ask them to write their ideas on the right hand side of the worksheet. Ask the group to share in a similar manner as described above.

5. Distribute **Handout #2**, Giving Positive Messages. Explain what it is and either read each item with trainees or allow the group a few minutes to look it over. Advise them that some of these examples might be useful as they do the next exercise.

6. Ask the group to break into pairs. Each is to take a turn being the PSS and talking to a client in a manner that reflects some of the ideas mentioned in Step 4. Ask trainees to try to use language that is encouraging. For example, if someone pointed out that a PSS will want to reinforce positive actions and behaviors, the dialogue might go like this:

- "What a wonderful way you did ________________. That's terrific."

Or perhaps someone said that helping a client learn from mistakes could actually help build self-esteem. Ask participants how they could turn difficult situations into an opportunity to promote positive self-esteem. **Example:** When the PSS arrives at Kate's house, she learns that today's mail contained a letter informing Kate that she had failed her G.E.D. exam. **Possible response:**

- "You must be disappointed. You had a lot of courage to take the GED. Taking the exam was a risk and people who never take risks, never get anywhere. When will you try again? What is important is that you tried and you can try again. How do you feel about this? What can you do to help make yourself feel better?"

- Kate doesn't respond to attempts to turn a negative into a positive experience. She says she will never try again because she is stupid. What do you as PSS do? How do you feel?

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Someone may have mentioned that by encouraging women to develop a particular skill area you can help her build self-esteem. For example, if a PSS admires Claudia's kitchen curtains and Claudia tells her she made them herself, what does the PSS say next? What effect might the conversation have on Claudia? Remind trainees that one of their roles as PSS is to help clients concentrate on some things they do well and about which they feel good. You may want to come back to this later on in the unit when discussing feelings.

7. Distribute **Handout #3**, A Self-Assessment Tool: Strengths and Skills. Explain that this handout may be used by PSS's when they are working with clients. It can be a tool to help clients to focus on their own strengths and skill areas. You may want to ask trainees to complete this form–just for themselves–as a way of becoming conscious of their own strengths and skills. In a similar way, PSS's can work with clients to complete the form to focus on the client's strengths.

8. Ask participants if anyone has ever tried to help build another's self-esteem. How does it feel when you feel like you aren't making any progress. How will you as a PSS respond? It is important that PSS's focus on the client. They should try to find ways to let the mother emphasize that she will still be important after the baby is born. Some home visitors have found that taking the time to help with practical details – like accompanying the mother-to-be to the grocery store and helping her make healthy food choices – helps the woman feel cared for and important.

9. Before moving to the next section, be sure to point out that encouraging clients to confront and solve problems, and making decisions that are right for them, is another way to help them build up their self-esteem. Trainees practiced how they would go about developing problem-solving techniques in the last unit. Those techniques can be used here, too.

B. HELPING PARENTS BUILD THEIR CHILDREN'S SELF-ESTEEM (45 minutes)

Rationale: A child's self-esteem is closely related to that of her/his parent's self-esteem. Just as PSS trainees recognize that their self-esteem must be positive before they can help their clients, similarly their clients must build positive self-esteem if they are to pass on feelings of self-worth and importance to their children.

Procedure: 1. **Exercise.** Positive Statements Only. Divide trainees into groups of four (if there are enough PSS's being trained to do this; otherwise, it can be done as a group exercise). Share the following rules for this exercise. Each person will speak for one minute to their group on the same topic.

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The other three are to listen carefully. When everyone has spoken, move on to the second topic and repeat the same process. Then do the same for the third topic; thus, everyone in the group eventually speaks three times. Speakers may make **only positive statements** about the topic. Speakers will be told when their time is up. Possible Topics:

- My special qualitles
- My home
- My childhood

When everyone has finished, process the exercise by first asking the "listeners" how they perceived each "speaker" after hearing all those positive statements. **Possible responses** might include:

- Self-confident
- Upbeat
- Self-satisfied
- Creative
- Self-conscious

Next ask participants how they felt when they had to talk about their special qualities and persons and places that are special to them. Discuss how one's role in a family or community might affect one's perception of self. For example, many of the trainees wear many hats–they are mothers, daughters, wives or girlfriends, aunts, neighbors, PSS trainees. How do they view themselves in each role? Does their feeling of "power" or self-assurance differ depending on which "hat" they are wearing? Why? Further, does being a member of a majority or minority cultural group affect their sense of self-esteem? Does it matter who defines the majority or minority culture? Does it matter if they are in their own neighborhood versus in a less familiar environment? Reflect on how these factors might affect the client's self-esteem. Is it more difficult to acknowledge one's strengths under certain circumstances than others? How does being in an unfamiliar situation–like pregnancy affect self-esteem?

The best way to build self-esteem is to focus on strengths. Remind the group that self-encouragement leads naturally to the encouragement of others. As parents identify and acknowledge their own strengths and resources, they will be able to recognize those of their children. This, in turn, will give the children the encouragement and positive recognition they need to feel good about themselves. Children will feel that they have value, and they can cope more creatively with life.

Children learn positive feelings like being capable, lovable, and important from their parents. Ask everyone to think back to when they made their "positive speeches" and imagine that they were saying all this to their children. The "special person in the family" was the child to whom they

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were speaking. How do they think their "children" will react? Why? Will it help their child's self-esteem? Why? If everyone is free to choose a positive attitude, why don't more people choose to do so? Give everyone an opportunity to voice their opinions.

2. When children experience success they begin to trust their own capabilities. Use the following idea to illustrate the importance of success. Ask participants to remember when their child or grandchild or a child they know was first learning to walk. Have them describe what they did to encourage that child. After everyone has had a chance to speak, point out the following:

- ☞ Perhaps there is no other time when children receive as much praise, encouragement, love, and rewards.
- ☞ Children will fall during this period, and that **could** lead to a sense of failure, but through our actions and encouragement, we can balance this frustration.
- ☞ This same level of encouragement and praise for success should be ongoing throughout a child's life. Is it? Why or why not?

3. **Encouragement Exercise.** Distribute **Handout #4**, Suggestions that Help to Encourage. Break into groups of two or three. Ask trainees to discuss specific activities they might suggest their clients do with their children to carry out encouraging actions. Ask one person in each group to take notes.

Before they begin, emphasize the following: When dealing with children, it is best to be specific when making encouraging statements. While it's okay to say things like "You're a good girl" it's better to be less general. Instead, encourage parents to say something more specific like "How fun! What a nice tower!"

At the end of 10 minutes, ask the recorder in each group to share that group's suggestions with the other trainees. [**Note:** If participants seem enthusiastic about these suggestions, you might arrange to have the suggestions typed up and distributed to all trainees. Suggest they keep them – as well as **Handout #4** – for use with families when they are making visits to homes with young children.]

4. **Group discussion.** Suggest to trainees that they think back to when they were children. What do they recall liking about the way they were treated? For those who are also parents, are there some things they tried to do differently as they raised their own children? Why?

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Ask participants to share tips to give to parents about ways to build their children's self-esteem. Ask for a volunteer to note responses on newsprint. If trainees come up with some suggestions that are not in their *Handbook*, suggest they write them in now.

C. COPING WITH FEELINGS (1 hour)

Rationale: How people feel motivates what they do and colors their perceptions of themselves. Discussions of feelings need to be tied back to self-esteem. people who deal with feelings positively tend to have a better sense of self-worth.

Procedure: 1. **Discussion.** Begin the discussion on feelings by asking the group to brainstorm some of the different feelings they have experienced in the past day. No feeling is too weird or silly to mention. Ask someone to record these feelings on newsprint. **Possible responses** may include:

- bored, angry, shy, calm, loving, frustrated, incompetent, happy, lonely, tired, worried, sad, sexy, comfortable, overwhelmed, embarrassed, confident, brave, annoyed, etc.

Encourage participants to discuss various aspects of feelings. Pose questions such as: How does the body respond to intense feelings? Probe: How did they feel while they were waiting to be interviewed for this job? How did their body respond? How did their body respond to their feelings on the first day of training? Or the first time they were asked to do a role play before the group? **Possible responses** might include:

- Increased heartbeat; flushed; butterflies in my stomach; I had diarrhea; rush of energy, etc.

2. **Exercise.** Ask each participant to think of a specific event or situation, and then tell the others how she felt and how her body felt. You may wish to begin by illustrating an example:

> "I just visited a friend who's sick with AIDS. Although he was in fine spirits, he looked so thin and had sores on his body. The visit depressed me, and I got choked up, but tried to cover up my feelings by making jokes about mutual friends. When I left his house, I cried. I couldn't eat; I'd lost my appetite."

When you process this exercise on the close relationship between the mind and the body, mention that people experience a complexity of feelings at the same time, and therefore there may be a complex response

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in the body. A person's body and tone of voice reveals what he or she feels.

Refer trainees back to the sections on nonverbal communication in Unit 2. What are some of the ways people express their true feelings? **Possible responses** include:

- their gestures, facial expressions (like smiling or frowning), posture (slumping or standing tall)
- looking attentive or preoccupied
- slamming a door or closing it gently
- shouting advice or reasoning in a calm voice

3. **Mini-lecture and discussion.** Cover the following points, and any others you choose to add:

✓ It's normal to experience a mix of emotions (happy and frightening feelings) at the same time. Ask trainees to give examples (such as how they felt on the day they gave birth, or began this training, etc.)

✓ As we grow and have new experiences (a first apartment, a new job, a new baby), we have feelings of failure as well as success. The failures may shake our sense of self-esteem.

Ascertain participants' ideas as to how one learns to cope with feelings? How did they? What are some cultural differences in the way people respond to feelings? Do we all cope the same way? Why or why not?

It is the response to feelings – or how a person copes – that is important. While people can't control their feelings, they can control how they respond to them. How? By choosing among a number of behaviors. For example, a person can feel angry enough to hit someone, but can choose or decide not to, and can instead walk away, or sit down and write about these feelings, or go to the gym and punch a punching bag. Similarly, a person can feel so happy that she wants to jump for joy, but it may not be appropriate to do that in the middle of a training session, so she decides to sit quietly and smile or just think pleasant thoughts. Ask participants to give other examples of choices in behavior.

✓ I'm frightened by an approaching stranger. My choices: walk faster; stay put; run away; scream for help, etc.

When making home visits, there will be times when a PSS will want to help clients understand that they are responsible for the action they take on their feelings, and not for the feelings themselves. If we all recognize

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this fact, we can all avoid much guilt. For example, there are days when parents both love and resent their babies at the same time. These feelings are not unusual. It's how they act on this mixture of feelings (their behavior) that counts.

4. **Exercise.** Look at **Training Aid #1**, Self-Esteem Situations. This exercise includes three brief scenarios describing three individuals who each reacted to a positive situation in a negative manner. Their reaction reflects their level of self-esteem. Read each scenario – or develop some of your own – and process this exercise with the discussion questions on the Training Aid. This exercise may be done as a large group or in smaller groups. Just be sure to have all trainees discuss together all the other choices or different responses each character could have made.

D. HANDLING ANGER AND MISHANDLING ANGER (1 hour)

Rationale: Learning to recognize and cope with feelings, particularly negative feelings, can be difficult. PSS's can help clients learn to cope with negative feelings.

Procedure: 1. **Mini-lecture.** Most people learn how to cope with feelings, such as sadness, anger, fear, and loss, but it takes time to develop these skills. Dealing with these feelings can be complicated. One example is the feeling of anger.

2. Ask each trainee to think of a personal situation when someone made her very angry. But for some reason, she couldn't bring herself to confront the person. What else could she do to ventilate her feelings? Gather as many alternatives as possible; have someone put these on newsprint, as they may be helpful later on when PSS are helping their clients to cope. **Possible responses** might include:

- talking to a trusted friend or relative (or to her PSS!)
- writing about her feelings in a diary
- writing a letter to the person, and then putting it away or tearing it up
- crying (which can be beneficial to both men and women)
- speaking directly to the person who has caused the anger
- picking a good time to talk, when there's no one else around and when neither of you is tired or otherwise pre-occupied
- trying to describe the way the other person has made you feel – i.e. When you ___________, I feel _____________.
- avoiding name calling
- avoiding jumping to conclusions or accusing the person of something he or she may not have done

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3. Before moving on to the next exercise, ask for trainee's perspective on a few more questions related to expressing feelings and emotions: How did they learn to deal with anger? Why do they think it's sometimes very difficult to deal with anger? Were any of them ever told, as children, that they were "bad" when they were angry? How do different cultural groups handle anger? What kinds of coping mechanisms can PSS's expect from their clients?

4. **Exercise:** Distribute copies of **Handout #5**, Ways People Handle Anger[1], and give trainees a few minutes to read the three situations that are explaining various responses to anger. Discuss one situation at a time, and give everyone an opportunity to participate. The following are major points that should be covered:

Situation A

In this family people deny their anger. Anyone who says "I never get angry" is either completely out of touch or is lying to herself as well as to the person to whom she's talking. People can defend themselves against anger by a constant show of sweetness – or toughness. But unexpressed, troublesome feelings can affect the body. Some say anger turned inward can lead to depression. It is better to recognize angry feelings and to deal with what's causing them.

Situation B

Taking anger out on oneself by using alcohol or other drugs to try to forget is not appropriate behavior. Mistreating oneself is a misdirection of feelings; and the anger returns as soon as the effects of the drugs and alcohol have worn off. In addition, it's double jeopardy: by adding a depressant (alcohol and some drugs) to anger, the mix is almost guaranteed to be more troubling than the original problem or situation that caused the anger.

Situation C

Letting things build up, and not dealing with whatever caused the anger, can turn anger to rage. Taking anger out on others is not constructive and can be dangerous. Nor is it constructive to blame others for how one feels. A person must learn to accept responsibility for her or his own feelings, and understand the consequences of her actions.

5. Process this exercise by asking trainees to reflect on similar situations that they may encounter with their clients. What will they say to their

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[1] This exercise, as well as other information on feelings, was taken from: Education Development Center, Inc., & Center for Health Promotion and Education, Centers for Disease Control, "Living with Feelings," 1983.

clients? The next exercise will help trainees deal with clients anger or other feelings.

E. RESPONDING TO THE FEELINGS OF OTHERS (30 minutes)

Rationale: Reflective listening is one way to help others deal with their concerns and feelings. It is one way PSS's can help clients deal with anger and other emotions.

Procedure: 1. Picking up on people's feelings and paraphrasing them are the first steps in reflective listening. These are skills trainees practiced in Unit 2.

The PSS is not the "rescuer." Her job is not to "fix" the bad feeling – only to help the client express it and come up with constructive ways to deal with it. A PSS cannot solve problems for her clients, but she can be a good listener. Many people are reluctant to bring their feelings out into the open by talking about them. Thus it is important to listen in ways that help the person with the problem deal with it more effectively. Active listening "invites" the speaker to think about what she is feeling, to say more, and to be less afraid of "bad" feelings.

2. Active Listening Role Play. Ask for four volunteers – 2 listeners and 2 speakers – to role play two conversations. Use the speakers first lines in **Training Aid #2**, Active Listening: Role Play, or make up original statements of your own that show strong feelings.

3. Share the instructions on the Training Aid with the participants. If a video or tape recorder is available, you might record the two conversations, and then play them back to the group.

4. To process the role plays, elicit the group's reaction to the following questions:

- In each scenario, did the two people seem to understand one another? How can you tell?
- What important feelings did the speaker reveal?
- What techniques did the listener use to keep the conversation going?
- Did the speaker seem to feel understood?

5. Make sure no one has any further questions or comments before moving on.

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F. SELF-ACCEPTANCE (40 minutes)

Rationale: Accepting one's feelings is a step toward self-acceptance and empowerment. PSS's can help clients identify feelings and work toward changing these feelings that are blocking self-acceptance.

Procedure: 1. **Mini-lecture and discussion.** Begin by asking the group what the words "self-acceptance" or "accepting yourself" mean. Come up with a definition that resembles the following:

✓ Self-acceptance means tolerating your mistakes and knowing that your less desirable traits are not so terrible. Self-acceptance is a process by which we learn to like ourselves, to dwell on those things we do well, but also to take constructive steps to change those feelings that can be obstacles to self-acceptance.

Point out that accepting ones feelings leads to self-acceptance. But it is not always easy to do this. We need to work at changing certain feelings we have that we wished we didn't have – e.g., feeling too shy to approach someone at a community or church gathering or feeling all alone. This change process can be learned, and it takes time.

2. **Activity.** Ask everyone to take out a piece of note paper. Ask them to express either in writing or with pictures "How I Feel About Myself." This is a private exercise, and no one else will see it unless they choose to share it. They should think about their unique qualities, their achievements, their strong points, and also their weak points. **Training Aid #3** contains a list of some points they might like to cover in their expression of themselves.

a. After about 15-20 minutes, ask trainees to reflect on what they have produced and to pick out two "feeling issues" that could be worked on – such as feeling better about their relationship with their mother, or feeling more self-confident. Then, for each feeling, ask trainees to set a goal for improving feelings on a particular issue by considering concrete steps they can take toward that goal.

b. Have them set up three columns at the bottom of their papers, with these headings: "Feelings"; "Goal"; "Steps Toward Goal." Consult **Training Aid #3** for an example of how to do this; write these headings on the chalkboard or newsprint. Give trainees about 5 minutes to complete their charts.

c. Don't discuss what they wrote or drew, unless they themselves suggest sharing. Instead, suggest they keep these reflections and goals

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someplace where it will be safe, and take them out every once in a while to check their progress.

d. Ask someone to review this exercise by sharing why she thinks you had trainees do it. How did they feel when confronting their feelings? When identifying some feelings on which to improve? Might their clients also benefit from going through this process? Why or why not?

Understanding our own feelings brings us a little closer to self-acceptance. This, in turn, helps build self-esteem.

G. SUMMARY AND REVIEW (10 minutes)

Procedure: 1. Refer back to the objectives on the first page of this module and rephrase them so they are questions. Ask for a volunteer to answer each question. Encourage everyone to participate.

2. Distribute post-unit evaluation forms.

3. Distribute Post-Unit Test.

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SELF-ESTEEM WORKSHEET

What I Can Do to Build Self-Esteem for:

Myself	My Clients

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GIVING POSITIVE MESSAGES

Sometimes we may not know what to say or do when we want to say or do something nice.

Here are some ways to give encouragement and positive feedback to people you care about – clients, family, co-workers, neighbors, etc.

Giving positive messages for BEING (who the person is), DOING (what he or she does), and CHANGING (doing something new) are three ways to build positive self-esteem.

What you can say:

- I'm lucky to know you!
- You are wonderful.
- Neat work.
- I like you.
- It's good to see you.
- Thanks for being you.
- I enjoy being with you.
- I appreciate your support.
- You encourage me to think.
- Thank goodness you're here.
- Thank you for being my friend.
- What beautiful gifts.
- You're a neat person.
- Way to go! Keep it up.
- Thank you for being so patient.
- You did that so well!
- It is great to know you.
- It is nice to have you here.
- It makes me happy that we're (riding, walking, playing, working) together.
- I love to share this (day, time, lunch) with you.
- It makes me happy that we are in the same (house, class, group, program, life).
- You carefully considered all your choices before making a decision.
- I like the new way you wear your hair.
- You have a good eye for color.
- Thank you for picking up the papers.
- Your willingness to address this problem is very important.
- I'd like to (see, hug, hold, kiss) you.
- You are important.
- Excellent!
- Nice job.
- I love you.
- You're super!
- I like to sit by you.
- You're a good team member.
- Those pictures are great.
- We work well together.
- What a clever way to do that.
- What a good listener you are.
- I hear you did a great job.
- What you said is very interesting.

Adapted from: Expanded Food and Nutrition Education Program (EFNEP), Mississippi Cooperative Extension Service, "Partners for Life: A Maternal and Infant Nutrition and Health Curriculum", Mississippi State University.

A SELF-ASSESSMENT TOOL: STRENGTHS AND SKILLS

1. These are some things I like in myself and feel good about:

2. What words would I like to have others use to describe me?

3. What new things have I learned in the past year?

   At home:

   In community activities:

   At my place of worship:

   From a magazine, book, or TV program:

4. Skills I would like to develop or improve in the coming year:

Adapted from: Education Development Center, Inc. and Center for Health Promotion and Education Centers for Disease Control, "Communicating in Families", 1983.

SUGGESTIONS THAT HELP TO ENCOURAGE

- Provide a warm, caring, and non-critical atmosphere.
- Value your children as they are.
- Have positive expectations of your children.
- Give lots of praise for the good things your children do.
- Have confidence in your children.
- Avoid comparing your children with their brothers, sisters and neighbors.
- Encourage and help your children to set up goals for themselves.
- Accept individual differences; each one of us is unique.
- Give your children the opportunity and freedom to make choices. Choices that are made in an atmosphere that is open and accepting will allow children to grow in confidence and self-respect.
- Show happy, pleasant expressions when interacting with your children and use a light, cheerful tone and voice.
- Accept mistakes in your children. We all make them. Help them to learn from these mistakes.
- Try to spend some time alone with your children, doing what they want to do. Be consistent and predictable.
- It takes time and effort to learn how to encourage effectively. The ability to encourage is a learned skill that improves with practice.

Adapted from: Butte County Office of Education, "Home-School Partnership Training for Migrant Parents", Oroville, California, 1988.

WAYS PEOPLE HANDLE ANGER

Situation A

"Anger? I think it's just better to forget it. Like my mother – she's so sweet, she never gets angry. Our family never argues. We're just cool all the time. It's better that way, you know. But sometimes I get these backaches..."

Situation B

"Well, I get some pot and I sit in my room and I think. Why bother talking about it? Nothing is going to change."

Situation C

"I usually just scream and slap my kids. I can't help it."

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SELF-ESTEEM SITUATIONS

Sonja: Having received the highest praise on her job evaluation, Sonja is happy. But she doesn't tell anyone; she fears being seen as "too smart" by her friends and colleagues. When Dean asks her about the evaluation, she shrugs and walks away.

Helen: Helen goes to her postpartum visit and tells the nurse that breastfeeding is not going too well. During the exam the nurse discovers that Helen has lost a lot of weight. She explains to Helen that eating nutritiously and drinking plenty of liquids is important when breastfeeding. Helen thinks about this, but skips dinner anyway.

Diane: When Diane finished making a playhouse for her daughter, her boyfriend said, "Wonderful. Just fix the roof where it's sagging and you're all set." Diane then began tearing apart the whole structure that she'd been working on for weeks.

Discussion Questions:

1. Complete the story. What do you see happening?
2. What issues are raised by each situation? What are people feeling?
3. How else could each person have responded to the situation? What are her or his other choices?
4. How would you have responded to each of these situations?

Adapted from: Education Development Center, Inc. and Center for Health Promotion and Education, Centers for Disease Control, "Living with Feelings," 1983.

ACTIVE LISTENING: ROLE PLAYS

Ask the group to divide into teams of three. One person is to think up a situation that a Parenting Support Specialist might encounter on a home visit.

The second person is to play the client; the third person is to play the PSS.

Advise each team that the scenes should include strong feelings, e.g. anger, sadness, depression, joy.

Instructions for the listeners (those taking the role of the PSS):

1. Communicate that she really cares about the client and that she is very interested in what the client is saying.
2. Demonstrate "active listening" skills such as saying "I see", "Tell me more", "Really" or "I hear you."
3. Use non-verbal communication techniques that also demonstrate active listening, such a leaning forward, shaking head in agreement, saying "mmm"; making eye contact, using gestures, etc. Most importantly, BE SINCERE. Make sure your non-verbal communication matches your verbal communication!
4. The listener should also make reassuring comments like "I'll call you tonight to see how things are going."
5. Ask teams to switch roles. Repeat the exercise with a new scenario.
6. Bring the entire group together. Process this exercise by emphasizing the fact that we can learn much more from each other, better understand situations and be more supportive when we communicate effectively.

Adapted with permission from
Resource Mothers, 1993.

HOW I FEEL ABOUT MYSELF: ISSUES TO CONSIDER

One of the things that many PSS's have found helpful is to maintain a personal diary. Share with participants this idea and suggest they keep a private notebook to write or draw thoughts about themselves.

Today's exercise is just a beginning in terms of focusing on themselves. Writing or drawing one's thoughts helps to gain perspective and a sense of control over one's life. Ask participants what issues about themselves they feel are important. These could include:

- What I value most about myself/What I feel about myself
- What I feel others value in me
- What really bothers me
- What I'd like to feel better about
- What I have trouble handling
- What I mostly need from other people – and get
- What I mostly need from other people – and don't get
- What I'd like to change about myself
- What I'd never change about myself
- What I care about myself
- Whom I feel I can really talk to
- What I love about myself
- What I feel best about
- What I feel rotten about

Write the issues on newsprint or the chalkboard. Ask participants to spend the next 10-15 minutes drawing and/or writing about themselves.

Are there things they want to work on? Goals to work toward? What steps need to be taken to reach those goals?

You may want to suggest a variation of the River of Life exercise introduced in Unit 1. Instead of looking back at what tributaries have contributed to where they are today, and what dams have blocked their progress thus far, ask participants to think about what bridges need to be built, what dams need to be broken, where is the river going? (Or what road will they take?)

OR you may wish to use the following outline:

Feelings that Need Work:

Feelings	Goal	Steps Toward Goal

Adapted with permission from Resource Mothers, 1993.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

Adapted with permission from Resource Mothers, 1993.

POST UNIT TEST

1. Describe 3 types of experiences that may lead to poor self-esteem.

   1. ____

   2. ____

   3. ____

2. Describe 3 ways in which parents can develop good self-esteem in their children.

   1. ____

   2. ____

   3. ____

3. Describe 5 ways to deal with frustration and anger.

   1. ____

   2. ____

   3. ____

   4. ____

   5. ____

Adapted with permission from
Resource Mothers, 1993.

POST UNIT EVALUATION

UNIT COVERED: ______

DATE ____________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? ______ If not, please explain.

Adapted with permission from
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5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

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Unit 5
USING CURRICULUM SUPPORT MATERIALS

Support materials can help Parenting Support Specialists communicate more effectively and will "support" what they say to their clients. A good picture, drawing, or handout can help a PSS get her client's attention, hold her interest, and help her remember instructions and information.

Objectives

By the end of this unit, participants will be able to:

- List five different kinds of support materials.
- Describe qualities of good support materials.
- Demonstrate the best use of support materials.
- Find or develop a support material for a given topic.
- Be familiar with all curricular materials available to the program.
- Be familiar with all the curricular materials at their individual sites.
- Describe the location and cataloguing of curricular materials.
- Develop sample lesson plans in response to specified needs using available curricular materials.

Time

5 hours

Outline

A. Introduction
B. Barriers to Effective Presentation of Materials
C. Qualities of Good Support Materials
D. Creating and Finding Good Support Materials
E. How to Best Use Support Materials
F. Summary and Review

Materials

- Resource Mothers. (1993). Handbook. Sterling, VA: INMED.
- Examples of good support materials (leaflet, booklet, comic book, videos)
- "Speedy Sally" Role Play **(Training Aid #1)**
- Partners in Learning Program
- Role Play Feedback **(Overhead #1)**
- Post-Unit Evaluation
- Post Unit Test
- Blackboard and chalk and/or flip chart and markers.
- Video Equipment: video camera, tripod, tape, VCR, and television

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Adapted with permission from Resource Mothers 1993.

Advance Preparation:

- Read the *Resource Mothers Handbook*, Chapter 17, "Using Support Materials."
- Ask participants to review Chapter 17 and come prepared to ask questions.
- Ask two participants to be prepared to act in role plays for the group. Give them their roles beforehand and let them ask you any questions.
- Write out the following "issues", each on separate slips of paper and put them in a container (a bowl, hat or envelope). Issues include: Reproduction, Family Planning, Child Safety, Infant Care, Breastfeeding, Child Nutrition, Child Growth and Development, Smoking, Child Abuse, Postpartum Care. (Add any others appropriate to your program.)
- Set up site visit to National Center for Education and Maternal & Child Health Clearinghouse for near end of training.
- Have files of materials on a variety of relevant topics available for participants to review.
- Try out video equipment. Set up camera to videotape role plays.

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A. INTRODUCTION (20 minutes)

Rationale: Studies have shown that adults learn best when they hear, see, and do the new skill or knowledge. After 60 days, adults remember 25% of what they hear, 45% of what they hear and see, and 70% of what they hear, see and do. The following exercise demonstrates the importance of support materials.

Procedure: **Demonstration and discussion:** Begin by giving a demonstration of the importance of support materials. Follow these steps:

1. Give a "lecture" about the importance of safety proofing an apartment where there are young children. Take about 5 minutes but do not use any support materials.

2. Ask participants to discuss what they just heard. Can someone summarize what was presented? What other things might have helped in the presentation?

3. Next, present the same information but this time use pictures of the safety hazards. It would be helpful to have a poster and/or pamphlets to hand out.

4. Ask participants how they feel about the second presentation.

5. Explain that anything you use to help you "support" your communication with clients can be called a "support material". Materials with pictures are often helpful because they help clients form an image of the idea and help them visualize it.

6. Ask trainees how they might include safety advocation in activities with a client: **Possible responses include:**
- Observe the client during infant caregiving and comment on things to be careful about.
- Observe the child at play and bring hazards to the mother's attention.
- Do a "walkthrough" safety checklist in the apartment.

7. Wrap up this discussion by saying something like this: "Now we will cover some of the types of support materials commonly used in both home and group session and how to use them."

B. BARRIERS TO EFFECTIVE PRESENTATION OF MATERIALS (1/2 hour)

Rationale: Client centered factors may impact on a mother's readiness to use learning materials.

Adapted with permission from Resource Mothers, 1993.

Procedure: 1. Discuss how client's literacy level may affect choice of materials.

2. Discuss how to deal with distractors in the home (TV/radio, other children).

3. Non-support from partner/other family members.

C. QUALITIES OF GOOD SUPPORT MATERIALS (20 minutes)

Rationale: Any support material that is used must have relevance to the audience for whom it is intended. Parenting Support Specialists can help identify appropriate materials for use in your program.

Procedure: 1. Ask the group what they think makes a good support material. **Possible responses** might include:

- It's easy to understand.
- Lots of pictures.
- Clear and accurate messages.
- Represent people in their community or experiences with which their community members are familiar.
- Current information and illustrations.
- Reading level is appropriate.

Share with the group several different support materials they might want to use with their clients.

Ask the group to discuss the advantages of using print materials. **Possible responses** might include:

- They are easy to store and carry.
- They don't need any special equipment.
- They reinforce messages presented verbally during home visits.
- They can be used as reference materials for the client.
- They provide a way of getting standard and accurate information to others, since clients often share their print materials with friends, relatives, or neighbors.
- They can counteract rumors and reduce fears that come from having no first hand experience with pregnancy, labor and delivery, family planning, and/or parenting.

2. Explain that, unfortunately, you don't have the time to review the use of all the support materials available for the project today. We have reviewed many materials and based our selection of materials on:

- accuracy
- reading level
- culture appropriateness
- attractiveness

Adapted with permission from Resource Mothers, 1993.

Because you will be using support materials throughout the training, each time you use a different material it can be evaluated by the group as to its effectiveness for future use. [**Note:** It is important that the PSS view all materials you plan to use in training and with clients, and share their ideas of relevancy.]

Be sure to cover the following points:

✓ It is important that every PSS view the media **before** she uses it, so that she knows what to expect, and can pick out some issues to discuss with her clients.

✓ Make sure the PSS feel the support material is appropriate before sharing it with clients. It shouldn't contradict information they are imparting. For example, old films on labor and delivery often have outdated information.

✓ Be aware of cultural differences between the characters represented in the material and the audience. For example, some videos may have all white actors/actresses and you may feel it does not accurately depict your clients or vice versa. You may feel this disqualifies the film, or you may be able to discuss this aspect of it and move on to the useful qualities of the film or video.

✓ If a PSS feels that a video would be useful during a home visit, and a client has a VCR, she may want to watch it with a client so she can discuss it with her.

D. CREATING AND FINDING GOOD SUPPORT MATERIALS (1-1/2 hours)

Rationale: Support materials need not be fancy or expensive to get a message across, but they need to be relevant to the client. Choosing the right support material can be a challenge.

Procedure: 1. Use the index cards with topics that you prepared and put them in some kind of container. Let the PSS choose a slip of paper from the container. Each PSS then takes 10 minutes to review materials on that topic. As the group comes back together, have each PSS present to the group which support materials, from the many that have been assembled, would be the most appropriate to get across the messages for that issue.

2. Ask if anyone has any other "issues" for which they would like support materials.

3. If any of the trainees show an interest or a particular talent in developing support materials for your program be sure to nurture this interest! Perhaps several of the trainees can get together and share their

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Resource Mothers 1993

creativity in order to develop fabulous teaching materials for everyone to share on home visits.

E. HOW TO BEST USE SUPPORT MATERIALS (2 hours)

Rationale: Support materials are most useful if they are "user-friendly" and Parenting Support Specialists use them effectively.

Procedure: 1. **Role Plays.** Ask the two people who volunteered to act out the "Speedy Sally" role play (**Training Aid #1**) to come up and do their role play.

2. Ask the group what they see happening. Presumably the group will complain that "Sally" made the following errors:

- She went too fast.
- She made no effort to find out what the client already new about the topic.
- She didn't go through each page of the materials with her client.
- She pointed to the text, and not the picture.
- She disregarded the client's confused expression.
- She didn't ask the client to repeat it in her own words.
- She took the support material with her so that the client could not refer to it or share it with her friends.

3. Ask for a volunteer to demonstrate more effective use of the same print material "Speedy Sally" used. Again, have the group provide constructive criticism.

4. Use cards from Partners in Learning to demonstrate use of these teaching aids.

5. Show a flip chart and explain that this can be an effective way of sharing information. Ask for another volunteer to demonstrate effective use of a flip chart. Remind her beforehand to be sure to hold the flip chart so that another person or a group can see the illustrations; always point to the picture and not the text. Have the group provide feedback to the volunteer.

6. Show a video and explain how to incorporate a video into a home visit. Ask for a volunteer. Remind people to stop the video at key points and get feedback. Throughout the rest of the training, be sure to include the use of support materials during role plays. Be sure to ask for the PSS' input on any videos and support materials that they feel would be good for your program.

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7. Show how to use a comic book style material. Ask for a volunteer to demonstrate.

8. Show how to use toys as teaching materials.

F. SUMMARY AND REVIEW (10 minutes)

Procedure:

1. Refer back to the objectives on the first page of this unit and rephrase them into questions. Have trainees answer the questions. Encourage everyone to participate.
2. Distribute the post-unit evaluation forms.
3. Distribute post-unit test.

Adapted with permission from Resource Mothers, 1993.

"SPEED SALLY" ROLE PLAY

Have "Speed Sally" read a small pamphlet on some topic relevant to the education the PSS will be asked to provide to their clients. Ask "Speed Sally" to read the pamphlet to the client very quickly. She should also do the following:

- Make no effort to find out what the client already knows about the topic.
- Skip pages of the pamphlet.
- Point to the text, not to the picture.
- Disregard the client's confused expression.
- Don't ask the client to repeat it in her own words.
- Take the support material with her so that the client cannot refer to or share it with her friends.

The client should look confused. She should try to ask questions, but continually get cut off or ignored. She should try to take the material from the PSS (at the end) to look it over herself, but the PSS will grab the material away.

Adapted with permission from Resource Mothers, 1993.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

Adapted with permission from Resource Mothers, 1993.

POST-UNIT EVALUATION

UNIT COVERED: ______

DATE____________________

1. Do you feel we covered all the information in this unit that we said we were going to?

____
____
____
____

2. What did you like best about the unit?

____
____
____
____

3. What did you like least about the unit?

____
____
____
____

4. Was the information in this unit presented clearly? ______ If not, please explain.

____
____
____
____

Adapted with permission from Resource Mothers, 1993.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7 Any additional comments?

Adapted with permission from
Resource Mothers, 1993

POST - UNIT TEST
UNIT 5

1. List 3 different kinds of support materials.

2. Describe 3 qualities of good support materials.

3. List advantages of using printed materials.

4. What things could be barriers to effective use of support materials?

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Unit 6
WORKING WITH FAMILIES

The purpose of this unit is to provide the Parenting Support Specialist (PSS) with an understanding of the family and healthy family functioning and behaviors. This knowledge will assist the PSS in helping families to maintain and develop healthy family functioning and behaviors. By enhancing family functioning, parental competence and parent-infant interaction will also be enhanced.

Objectives

By the end of this unit, participants will be able to:

- Describe the concept of family.
- Describe the functions of the family.
- Describe the family life cycle.
- Describe how ethnicity influences family beliefs and behaviors.
- Identify healthy family behaviors.
- Demonstrate ways of helping families to maintain and develop healthy family functioning and behavior.

Time

6 hours

Outline

A. Overview/Definitions and Trends of Families
B. Family Functions
C. Family Life Cycle
D. Healthy Family Behaviors
E. Ways to Promote Healthy Family Functioning and Behaviors
F. Family Case Studies and Practice Sessions
G. Summary and Review

Materials

- Berkey,K. & Hanson, S. (1991). Pocket Guide to Family Assessment and Intervention. Baltimore: Mosby.
- Bromwich, R. (1978). Working with Parents and Infants. An interactional approach. Texas: Pro-Ed.
- Friedman (1986). Family Nursing Theory and Assessment. Connecticut: Appleton-Century Crofts.
- Gillis, C., Highley, B., Roberts, B., & Martinson, I. (1989). Toward a Science of Family Nursing. New York: Addison-Wesley.
- Family Case Study #1 **(Training Aid #1)**
- Family Case Study #2 **(Training Aid #2)**
- Family Case Study #3 **(Training Aid #3)**

- Family Life Cycle **(Handout #1)**
- 15 Strengths or Traits Found in Healthy Families **(Handout #2)**
- Top Stressors for Families **(Handout #3)**
- Role Play Feedback **(Overhead #1)**
- Post-Unit Evaluation
- Post-Unit Test
- Easel with Chart Paper; markers or blackboard and chalk
- Video Equipment: video camera, tripod, tape, VCR, and television

Advance Preparation

- Review above listed references.
- Review handout materials; make transparencies as needed.
- Try out video equipment. Set up camera to videotape role plays.

A. OVERVIEW/DEFINITIONS AND TRENDS OF FAMILIES (45 Minutes)

Rationale: The purpose of this training session is to help the Parenting Support Specialists (PSS) to understand the importance of the family unit for the mother-infant and/or parent-infant interaction. This unit will also focus on developing an understanding of how the family influences the health and behavior of the mother and her infant. The PSS will also learn how to assist the mother to maintain and develop healthy family functioning and behaviors.

Procedures: **Discussion.** Begin by having participants address the following questions:

* What does the term "family" mean to each of the participants?
* How do they think that families have changed?
* What do they think are the strengths of the families they will be visiting?
* What do they think will be the needs of the families they will be visiting?

Combine lecture and discussion to include the following information:

1. Current Family Trends
   - Increase in single-parent families.
   - Increase of working mothers with young children.
   - Women have fewer children.
   - Increase of the number of women who remain single and care for children.
   - Increase in the number of children who live in poverty.
   - Increase in the number of families where violence threatens the well-being of the family and its members.

2. Historical Trends
   - Usually male and female parents were responsible for caring for children.
   - Families were often self-sufficient, they raised their own food, made their own clothes, educated their own children and provided their own recreation.
   - Having many children was seen as valuable because children could work and help support the family.
   - Families stayed close to its members, even when children grew up and left the family.
   - Older members were often close by to help guide and assist new parents.

3. Family Definitions
   - Many definitions are based on the idealized image of father, mother and 2 children with a host of extended family members close by; father = breadwinner, head of family; mother – homemaker.
   - However, today (1990's) only about 14% of American families are really like this idealized image.
   - Ask participants to give definitions of family. Discussion will probably bring out these ideas:
     1. Persons joined by bonds of marriage, blood or adoption.
     2. Members of family usually live together in a single household.
     3. Family members interact with and communicate with each other in social roles such as father-mother, husband-wife, son-daughter, sister-brother.
     4. Family shares common culture/beliefs/values.

- Suggest a Broad Definition of Family: **A family is composed of people (2+) who are emotionally involved with each other and usually live in close geographical proximity** (Friedman).
- Extended Family: **The family of procreation and other blood related persons; "kin" = grandparents, aunts, uncles, cousins.**

4. Why is it important to understand families, family function and family behavior?

The family unit is seen as the basic unit of society and the first social structure in society that most individuals experience. This primary social structure is where family members first learn and practice health promoting and disease preventing behaviors.

- Families are responsible for certain tasks that affect the health and well-being of each member.
- Encouraging optimal (best possible) health for each family member is an important part of the family's life style.
- Family Responsibilities Related to Health:
  1. Developing skills in the individual members so they can care for themselves.
  2. Provide family members with sufficient social skills, contact and physical materials so they can take care of themselves. For example:
     - knowing when a family member is sick or well;
     - how and when to call the clinic or doctor if a family member is sick;
     - how to get a Medicaid card or other medical card to cover the cost of a visit to the clinic or to medicines; and
     - how to give medicines to a sick infant.
  3. Promoting independence and individual personality for each family member.
  4. Promoting family behaviors that help to make the family's well-being and quality of life good for all family members (Berky & Hansom, 1991).

B. FAMILY FUNCTIONS (45 Minutes)

Rationale: Families have certain jobs and roles that its members carry out, usually on a daily basis. Understanding these functions is the first step in being able to assist families.

Procedures: Ask participants to state what they believe are the tasks/roles of families.

Be sure to include the following:

FAMILY FUNCTIONS (Friedman) are:
1. ***Economic***: To provide shelter, food, clothes for all of the family members.
2. ***Confer Status***: To give every member a feeling of importance; a sense of belonging.
3. ***Education***: Teaching children basic things such as colors, numbers, reading to children, listening to music with children.
4. ***Socialization of Children***: To help children learn the skills, behaviors and roles that they will need to get along with others and to be successful as adults in the society.

5. ***Health Care***: To teach family members how to stay healthy, keep doctor or clinic appointments, get baby shots, eat properly, sleep enough, etc.
6. ***Religion/Spirituality***: To teach the family's beliefs and values about life, work, death, love, God or Supreme beings.
7. ***Recreational***: To play, have fun and relax together.
8. ***Reproductive***: To expand the family by having or adopting children.
9. ***Affective***: To meet the love and belonging needs of family members.
10. ***Protection of Family Members***: To make sure the family members are safe and kept free from harm (Gillis et al).

FAMILY DEVELOPMENTAL TASKS:

1. Establish and maintain a home.
2. Satisfactory ways of getting and spending money.
3. Satisfactory ways of dividing work among its family members.
4. Mutually satisfying intimate and sexual relationships.
5. Open ways of intellectual (thoughts) and emotional (feelings) communications.
6. Workable relationships with extended family members.
7. Competency in bearing and rearing children.
8. Ways of interacting and communicating with neighbors and community members.
9. Workable philosophy (beliefs and values) of life.

Today many other institutions are taking over family functions: Ask participants to give examples.

Summarize the discussion with the following examples:
Be sure to include the following information

Economic Stability
- WIC, AFDC, Medicaid, homeless shelters, unemployment insurance

Protection
- Police and fire departments, social workers, gangs, community/neighborhood groups

Values/Religion
- Schools, churches, support groups, television/media, music, peer groups, industry advertisements

Educate the Young
- Schools, churches, social groups, gangs, television/media

Confer Status
- Schools, churches, laws (16 to drive, 18 to vote, 21 to drink), gangs, peer groups

Today's families are expected to provide primarily for love, emotional and belonging needs such as:
- Love
- Intimacy
- Acceptance
- Nurturing

- Caring
- Individuality
- To give and to be given to
- To share joy of good times
- To provide support during hard times

PARENT QUALITIES → HEALTHY FAMILIES → OPTIMAL INFANT OUTCOMES

C. FAMILY LIFE CYCLE (45 Minutes)

Rationale: The family is ever changing. The changes are predictable. Knowing what stage the family is in will assist the PSS in helping the family to maintain and develop its healthy functioning.

Procedures: Display Transparency of Family Life Cycle.**Handout#1** Explain that each stage is determined by the age of the oldest child. Ask the participants to describe the stage of their family. Explain that the discussion will focus mostly on Early Childbearing Family (Stage II) and Family with Preschool Children (Stage III). Discuss the Developmental Tasks and Health Concerns of Stage II and Stage III families.

STAGE II: EARLY CHILDBEARING FAMILY

Major Parenting Concerns:

- "Parenthood" is often seen as a crisis

- By "crisis" is meant that parents may feel unprepared to take care of the baby. This may include daily care tasks and having the material items and help from family and friends to be able to take care of the baby or other children in the family.

- The uncertain feelings about being a parent may be related to:
  - not being prepared to be a parent either for the new baby or for the baby plus other children in the family.
  - having ideas that parenting will be "fun all the time" or "easy all the time" or won't take much time.
  - getting used to new relationships or changes in former relationships - such as:
    - * mother-father
    - * sexual intimacy
    - * learning how the new infant will grow and develop
    - * family planning (both birth control and when to have another baby)
    - * new relationships to "kin"
    - * relationships with friends and neighbors

Health Concerns of New Parents
- pregnancy classes and childbirth classes.
- well-baby care - going to the clinic or baby's doctor.

- when to get baby shots (immunizations).
- child growth and development.
- counseling/knowledge.
- birth control or when to have another baby (family planning).
- family relationships.
- parenting (relationships with each other, potential problems).

STAGE III: FAMILIES WITH PRE-SCHOOL CHILDREN

Major Parenting Concerns

- Safety of home environment for the toddler and pre-school child such as protecting from burns, drinking cleaning products or medicines, electrical injuries, drowning in a bathtub, falls, etc.
- Increased trips to the doctors office or health care center with children.
- Adequate childcare or babysitting when parents have to be away from the infant or other children.
- Having time alone with that special person.
- Teaching toddlers social skills and manners.
- Helping other family members get used to the new infant–helping older children to get along with the new infant (sibling rivalry).
- Getting older children (toddler, pre-schoolers) ready for that first separation from parents (such as babysitters, pre-school or daycare).
- Birth control or when to have another baby.
- Having time for yourself and doing some of the things you like doing (private time/time alone).

Health Concerns for Parents

- Many childhood diseases that children may catch such as colds, chicken pox, ear infections.
- Accidents (falls, burns, poisonings).
- Time for couple relationships.
- Brother - sister relationships (Sibling rivalry).
- Birth control or when to have another baby (Family Planning).
- Growth & development education related to their children.
- Parenting problems (setting limits, discipline of active toddler or pre-school child).

D. HEALTHY FAMILY BEHAVIORS (45 Minutes)

Rationale: Recognizing healthy family behaviors will assist the PSS to help families maintain and develop healthy behaviors.

Procedures: Review examples of healthy family behaviors. Display the "15 Strengths or Traits Found in Healthy Families" Transparency.**Handout#2** Have participants describe what might cause a family to not have these healthy behaviors – what are stressors for families. Make a list on flip chart.Use transparency "Top Stressors for Families"/**Handout#3** to conclude this discussion.

E. WAYS TO PROMOTE HEALTHY FAMILY FUNCTIONING AND BEHAVIORS (45 MINUTES)

Rationale: The PSS will often have an opportunity to assist the family to maintain and develop healthy function and behaviors.

Procedures: Discuss what the PSS can do to help family. The PSS should use the following strategies for home visits:

1. Inquire about how things are going with mom and other family member.
2. Allow sufficient time for mom to express concerns.
3. If a problem is identified help the mother to use her problem-solving skills to develop solutions.
4. Always start with describing or praising the strengths she and her family have previously demonstrated.
5. Be prepared to make referrals if necessary.
6. Help mom to involve all family members in the solution.
7. Be sure to follow-up with concerns at the next visits and/or phone calls.

F. FAMILY CASE STUDIES AND PRACTICE SESSIONS (120 Minutes)

Rationale: This session will provide the PSS with the opportunity to use newly gained knowledge to practice with family scenarios she is likely to encounter during a visit. Practice will increase the PSS confidence.

Procedures: Present the Case Studies Training Aids#1,2,3 (3 CASES, ALLOW 40 MINUTES FOR EACH). Have participants work in pairs to:

- Identify the family life cycle stage.
- Describe the family tasks.
- Describe the potential problems.
- Describe the family's strengths.
- Describe how the PSS might help the family to identify the problem and come up with potential solutions.

The Trainer may have the participants work in pairs. One participant is the client and the other is the PSS. The client describes the family situation and the PSS listens and tries to come up with answers to the case study questions. After the role-play have the total class come up with the answers to the case study.

Encourage the participants to review their Resource Manuals and handout materials to prepare their presentations. After about 15 - 20 minutes have each pair present their case study and role-play their presentation. Allow participants to ask questions about content covered or concerns they may have.

G. SUMMARY AND REVIEW

1. Trainer or trainee should summarize this unit in a general way.
2. Review objectives stating them in the form of questions.
3. Handout post-unit evaluation.
4. Distribute post-unit test.

FAMILY CASE STUDIES

CASE STUDY #1: MARY BROWN

Mary Brown is a 20 year old, first time mother with a 2 week-old infant named Angela. She stated to the home visitor that this was not a planned birth and that after she got used to the idea of the pregnancy she had hoped for a baby boy. Mary lives alone. She completed a two year college program for data processing. The baby's father has told Mary that he does not want to be involved with Mary or Angela. Currently Mary receives WIC and is drawing unemployment insurance. She hopes to be able to find a job when the baby is 4 months old because that is when her unemployment benefits stop.

Mary was a quiet, soft-spoken women who did not maintain consistent eye contact with the home visitor as she talked. She appeared caring and tender toward her baby. Angela had been born 3 weeks early. Mary had chosen not to breastfeed and she was frustrated about how hard it was to get Angela to take her feedings during the last 2 weeks. Angela does not appear to be gaining weight. Mary stated that sometimes she feels overwhelmed when she is alone with her daughter. "I just don't know what to do especially when she is crying!"

Identify the family life cycle stage:

Describe the family's developmental tasks:

Describe the family's strengths:

Identify potential problems for this family:

Describe how the PSS might help the family identify family's problems and come up with potential solutions:

FAMILY CASE STUDIES
CASE STUDY #2: MAXINE AND BOBBY

Maxine and Bobby are first time parents of fraternal male twins. Both parents are very excited about the twins and so are both sets of grandparents. Maxine and Bobby live with Bobby's family. Bobby and Maxine are both 18, neither has completed high school nor are employed. They are receiving WIC and AFDC. Both parents seem very loving and caring toward the babies and on the surface everything seems to be fine. However, as you begin to talk with parents you learn more about the family.

The babies were born 3 weeks early. Maxine says she feels like the feedings go on day and night nonstop and she gets no sleep at night. Because the babies were early she knows she has to feed on demand. She states that "some days they feed every 2 hours, so as soon as I finish with one baby the other baby is ready to feed. Sometimes, I just want to leave them in the crib because I never seem to get a break."

Maxine was getting little sleep, although she tried to nap when she could. She tried to get Bobby to help with the feedings so she could nap longer. Now the babies are getting close to four months old and things appear to be calming down. But now, Maxine and Bobby state the infants want them to play with them. Both parents state that its hard to keep the house in order and they have little time to be a couple because Bobby's parents are always around. Bobby says sometimes he feels left out because Maxine is either with the babies or she is too tired. Sometimes Bobby just leaves to hang out with his friends.

Identify the family life cycle stage:

Describe the family's developmental tasks:

Describe the family's strengths:

Identify potential problems for this family:

Describe how the PSS might help the family to identify the family problems and come up with potential solutions:

FAMILY CASE STUDIES
CASE STUDY #3: TARI

Tari recalls that her labor with Jamal was long and difficult. She thinks that was just the beginning. Jamal has been to the clinic and the hospital at least 6 times in his 6 short months of life. Tari is 19 years old and she has a little girl Tara who is now 3 years old. Tara is according to her mom a "good girl and she has never been sick".

Tari works part-time, although she has not been able to work since Jamal's birth. She lives with her older brother's family. Her brother has given Tari the extra bedroom. Tari and both children share the bedroom. Jahri, the father of both babies sends her some money about once a month for the children, and Tari is receiving WIC. Tari and Jahri get along o.k. but they don't see each other often. Jahri is a truck driver and he is away a lot.

Tari says it takes a lot of time to be a mother, especially with 2 children and having to get Jamal back and forth to the hospital and clinic. Tari states sometimes she thinks it is just not fair because she doesn't get to do things with her friends and she really misses that. Sometimes when the children's father comes around, he might take them all to McDonald's and they all like that. Tari states she has very little help from her mom with either of the children. Sometimes her brother's wife helps a little with the children and will watch them for a couple hours if Tari wants to go out. Tari seems to feel comfortable around her children but she seems to get easily frustrated with all of the activities of both children. Sometimes, she admits that she doesn't keep appointments because it's just to much of a bother.

Identify the family life cycle stage:

Describe the family's developmental tasks:

Describe the family's strengths:

Identify potential problems for this family:

Describe how the PSS you might help the family identify the family problems and come up with potential solutions.

FAMILY LIFE CYCLE

STAGE	DESCRIPTION
I	BEGINNING FAMILIES STAGE OF MARRIAGE (JOINING)
II	EARLY CHILDBEARING FAMILY (oldest = infant to 30 months)
III	FAMILIES WITH PRESCHOOL CHILDREN (oldest = 3 - 5 years)
IV	FAMILIES WITH SCHOOL - AGE CHILDREN (oldest = 6 -12 years)
V	FAMILIES WITH TEENAGE CHILDREN (oldest = 13 + years)
VI	LAUNCHING CENTER FAMILIES (from first child to leave home through the last to child to leave home)
VII	FAMILIES OF MIDDLE YEARS (empty nest to retirement)
VIII	FAMILIES IN RETIREMENT AND OLD AGE (retirement to death of both spouses)

15 STRENGTHS OR TRAITS FOUND IN HEALTHY FAMILIES

Open Communications with all Members

- Communicate and listen.
- Have a balance of interaction among them.
- Foster time for conversation or being together.
- Identify problems and seek help.

Respect for Family Members

- Accept and support each other.
- Teach the members family rules, social expectations, etc.
- Develop a sense of trust.
- Respect the privacy of each other.

Teach Family Values and Beliefs

- Teach a sense of right and wrong.
- Have rituals, traditions and customs.
- Have a shared religion/values/beliefs.
- Value service to others (helping others).
- Show a sense of shared responsibility.

Play and Have Fun Together

- Develop a sense of humor and play.
- Shared leisure or recreation time.

TOP STRESSORS FOR FAMILIES

Money Problems

Children's Behavior Such As

- fighting.
- having to clean them up many times a day.
- having to pick up toys or clean up after them several times a day.
- always having children in the way - making it hard for mom to do her chores.
- needing to keep a constant eye on the children.

Insufficient Couple Time

- hard to find a baby sitter.
- children are always around.
- hard to be alone with each other.
- children interrupt conversations.

Lack of Shared Responsibility in Family

- mom having most of the responsibility for caring for the children.
- having to change your schedule a lot to meet other people's needs.
- having to take kids places without help from other family members.

Communicating with Children

- children don't listen.
- children don't do what the parent asks.
- children whine, complain or cry a lot.

Insufficient "Me" Time

- children always around.

Family Play Time

- not enough time for family members to play or relax together.
- children want to be entertained all the time.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

POST-UNIT EVALUATION

UNIT COVERED: ______

DATE ____________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? ______ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

UNIT 6
WORKING WITH FAMILIES
UNIT TEST (10 POINTS)

I. FAMILY CHARACTERISTICS (2 POINTS)

Briefly describe characteristics of a family:

____

____

____

____

II. LIST 6 FAMILY FUNCTIONS (3 POINTS)

____

____

____

____

III. INDICATE WHICH OF THE FOLLOWING STATEMENTS IS TRUE OR FALSE ABOUT FAMILIES (5 POINTS)

_____ 1. Families are totally responsible for the education of all their members.

_____ 2. Families are expected to provide primarily for the love and emotional needs of their members.

_____ 3. Many new parents feel unprepared or overwhelmed with parenthood or may see it as a "crisis".

_____ 4. Some families may find talking with their children to be a stressor.

_____ 5. When the PSS is working with a family it is best to start with the family problems.

Unit 7
CULTURAL DIVERSITY/ETHNICITY AMONG FAMILIES

The District of Columbia has a significant amount of diversity in its population. Increasing awareness of how cultural diversity can influence families and parenting is important in the understanding of different people. Having this awareness is vital to providing intervention that is culturally sensitive to the clients being served.

Objectives

By the end of this unit, participants will be able to:

- Define 'Culture' and 'Ethnicity'.
- Discuss how cultural diversity can influence families and parenting.
- Describe ways in which they can become more culturally sensitive.
- List several cultural myths and discuss information needed to dispel these.
- Demonstrate several strategies for culturally sensitive intervention.

Time

3 Hours

Outline

A. Overview of Culture and Ethnicity
B. Examples of How Culture and Ethnicity Impact the Families that the PSS will be Visiting
C. Summary and Review

Materials

- Friedman, M. (1986). Family Nursing: Theory and Assessment. Connecticut: Appleton-Century-Crofts.
- Holin, A. (1994). Cultural Sensitivity and the African-American Family. (unpublished paper).
- Kavanagh & Kennedy (1992). Promoting Cultural Diversity. Newbury Park: Sage.
- Leahey, M. & Wright, L. (1987). Families and Life Threatening Illness. Pennsylvania: Springer.
- Leahey & Wright (1987). Families and Chronic Illness. Pennsylvania: Springer.
- Leahey & Wright (1987). Families and Psychosocial Problems. Pennsylvania, Springer.
- Lynch, E. & Hanson, M. (1992). Developing Cross-Cultural Competence: A Guide for Working with Young Children and Their Families. Baltimore, MD: Paul Brooks Publishing Co.
- Hoflin (1994). A Cultural Journey. **(Handout #1)**
- Myths for Discussion **(Handout #2)**
- Flip Chart
- Role Play Feedback **(Overhead #1)**
- Post-Unit Evaluation
- Post-Unit Test
- Video Equipment: video camera, tripod, tape, VCR, and television

Advance Preparation

- Review above references.
- Make sufficient copies of handouts.
- Try out video equipment. Set up camera to videotape role plays.

A. OVERVIEW OF CULTURE AND ETHNICITY

Rationale: The PSS will likely come in contact with families whose culture and ethnicity is different from their own. In order to provide appropriate intervention, the PSS will have to be knowledgeable about the many aspects of the prevailing culture as well as about individual family differences.

Procedure:

1. Definitions of Culture and Ethnicity

- Ask the participants to tell what culture and ethnicity mean to them..
- Be sure to include the following information in your discussion.

Culture: the shared values, beliefs, behaviors, ideas, practices of a group of people, symbols (ie.clothing, language, decorations).
Multi-cultural: several different cultures or sub-cultures.
Cross-cultural/trans-cultural: learning to deal or bridge the gaps across several different cultures.

As an analogy, multi-cultural is like children engaged in parallel play in which there are several different non-interactive activities going on. Cross-cultural is where many children are playing a game in which there is communication and interaction.

Ethnicity: common racial make-up, some similar biological/genetic background, common geographical origin of people, who often share the same culture.

- Recognize that the USA has the largest ethnic diversity of any major country:
  The African-Americans are the largest ethnic group.
  Latinos are the second largest ethnic group in the USA.

2. Understanding How Culture and Ethnicity Influence Families

During the discussion, try to elicit the following information from the group:

- The core concept of ethnicity is that there is a common culture.

- Ethnic groups often have shared ideas about:
  kinship patterns
  religious affiliation
  language
  nationality
  physical features and appearances

- Therefore families of certain ethnic groups often have similar idea and practices related to:

health
sickness
parenting
childrearing practices
child discipline
male-female relationships

3. Culture Shock

Discuss with participants what 'culture shock' means to them and how it might impact them. Be sure to include the following information in the discussion:

- This occurs when an individual has a series of encounters where personal values, attitudes, beliefs and behaviors are challenged by another person's values, attitudes, beliefs and behaviors. These encounters usually disturb the balance of the individual (Hoflin, 1994).
- There is a discomfort in relating to another culture. This discomfort is usually related to not understanding the culture of another group or person.
- The PSS may experience the following feelings as they work with their families:

  - First enthusiasm, high spirits as you begin to work with the families.
  - Next you may find that your problem-solving or help strategies do not work with the families.
  - You may find that you disapprove or do not understand the habits or behaviors of the families you are working with, especially if they are different from yours.
  - You may realize that your education and background are different from the families and that makes it hard for you to understand the families.

4. Practical Suggestions and Advice for the PSS

Generate ideas from participants about what they can do to be more culturally sensitive. Use a flip chart to record ideas. Include the following in your list:

- It will be important to understand the culture, the behavior, habits, knowledge and beliefs of the families.
- Consult with colleagues and others who have experience with the families.
- You can increase your awareness, sensitivity and appreciation of the culture of the families by:

  - Gathering as much information about the culture as possible
  - Identifying lay people who can serve as cultural guides or mentors.
  - Finding ways to build trust with the members of the families.
  - Trying in a personal way, to experience the culture, learn about the holidays, foods, celebrate or get involved with community activities.
  - Learning the language and slang of the culture.

DO NOT MAKE ASSUMPTIONS ABOUT ALL MEMBERS OF THE CULTURAL GROUP BASED ON WHAT YOU LEARN FROM THE PERSONAL EXPERIENCES OF A FEW MEMBERS

Sometimes you may have to be sensitive to other family needs and feelings before you can address the purpose or planned intervention for the home visit.

You may need to earn the trust of the families. You can do this by being sensitive to their needs, concerns and beliefs. Your style of interaction should include warm, empathetic listening and verbalizations. You want to exhibit caring and understanding.

Have the group engage in the following exercises:

Practical Exercise #1 (30 MINUTES)

1. Have PSS sit in groups. Ask them to talk about people they know of different ethnic backgrounds and the practices that they know about related to these families which are different and/or similar from their own family practices.
2. Were they surprised by the practices?
3. What do they think about the similarities?
4. What do they think about the differences?
5. Do the PSS believe these similarities or differences will effect how they might give care to such a family? In what ways could this happen?

Practical Exercise #2 (30 MINUTES)

1. Have the PSS pair up(P1 and P2).
2. Ask one to tell their partner about a negative situation that happened to them related to their ethnicity. Tell how she felt and what she did.
3. Ask the partner P2 to think about what she might tell the P1 about how to make the situation more positive and/or help her handle a similar situation in the future.
4. Role play these situations in the group. Focus on the feelings and behaviors of the P1 and P2.

B. EXAMPLES OF HOW CULTURE AND ETHNICITY IMPACT THE FAMILIES THAT THE PSS WILL BE VISITING

Rationale: There are many myths about culture and minority status. The PS must be aware of these and learn how to dispel them. At the same time, it is also important to understand the basic facets of the African-American culture in order to deal sensitively with families.

Procedure: Present the following information:

Many of the families that the PSS will be visiting will be African-American.

- In African-American families, the extended family is often intact and provides significant support for new mothers and infants. So, when possible and agreed to by the new mom, they should be involved in the interventions for the family.
- In African-American families, it is important to recognize the role and influence of the older woman, i.e., grandmothers, or mother of teen mother. Again, they may be gatekeepers for the family's health habits and practices and should be involved in the intervention if agreed to by the new mom.
- Many African-Americans rely on themselves or friends to care for them when they are sick.
- Many African-American families do not trust health care workers - it is possible that they may not trust you at first. Because they don't trust, they may not come to a doctor or clinic until they can no longer care for themselves. Sometimes they may not do exactly what the nurse or doctor tells them because of fear or mistrust. THIS IS WHERE THE PSS CAN BE VERY HELPFUL TO THE FAMILY BY EMPHASIZING THE IMPORTANCE OF HEALTH CARE.
- African-American families in general value and love their children although they may be strict with them.
- Family ties and kin are very important to African-American families.
- BUT YOU MUST ALWAYS REMEMBER THAT NOT EVERY FAMILY IN AN ETHNIC GROUP IS ALIKE.

Practical Exercise #3 (30 minutes)

MYTHS FOR DISCUSSION (Source: Kavanagh & Kennedy, 1992). **HANDOUT #2**

1. It is a myth that educated and professional individuals do not have minority status problems or involve themselves in such issues.

2. It is a myth that personal concern with social stratification issues implies immaturity and non-professionalism.

3. It is a myth that institutions must adapt to the needs of minority groups or individuals, rather than minorities adapting to social institutions.

4. It is a myth that you can "get the feel" or "sense" of another culture without having to learn about its social organizations and social processes.

5. It is a myth that health care providers cannot be reasonably prepared to handle cross-cultural and other situations involving diversity because health care personnel in the United States deal with people from more than 100 ethnic, racial, and cultural groups.

Have PSS read myths.

Lead a discussion with the PSS about their reactions to the myths.

Be sure to use the following materials as a guide for the discussion.

POINTS TO EMPHASIZE DURING THE DISCUSSION:

MYTH #1

1. Regardless of educational or professional background or experience, workers of ethnic/minority groups deal with the same issues and prejudices of all members of that group.

MYTH #2

1. Stereotypes still persist related to one's ability to do a job according to: SEX, RACE, ETHNICITY, AGE.

2. It is a mistake to believe that social stratification issues are not relevant for all workers.

3. Even employment situations are stratified and inequitable.

MYTH #3

1. Most health care agencies and providers expect clients to adapt to the system.

2. Health care systems are based upon routines to increase efficiency.

3. Argument is that individualized care takes time and costs money.

MYTH #4

1. People do need to be sensitive and aware of cultural groups.

2. People need to be knowledgeable about patterns among groups of people...this gives/helps to empower health care providers to make valuable interventions.

MYTH #5

1. Complete knowledge of a culture is not the goal.

2. General knowledge about cultural patterns and social organizations is helpful to know what questions to ask...to gather information needed to provide interventions for families.

C. SUMMARY AND REVIEW

1. Rephrase the objectives of this unit into questions. Have participants respond.
2. Review the following as the last statement for this unit:
   RESPECTING OUR DIFFERENCES - 'What's in it for you?'
   * The more tolerant you are, the more open you are to learning about others.
   * The more you learn, the less you fear.
   * The less you fear, the more comfortable you will feel in all types of situations, with all kinds of people.
   * The more you get along with other people, the more successful you are ... and the more interesting your life becomes.
3. Distribute Post-Unit Evaluation.
4. Distribute Post-Unit Test
5. Distribute 'A Cultural Journey' for use as individuals decide. Encourage the participants to complete this activity.

A CULTURAL JOURNEY

Adapted from Developing Cross-Cultural Competence: A Guide for Working with Young Children and Their Families (eds.) Eleanor W. Lynch & Marci J. Hanson, (1992) Baltimore: Paul Brooks Publishing Co.

ORIGINS

1. When you think about your roots, what country(ies) other than the United States do you identify as a place of origin for you or your family?

2. Have you ever heard any stories about how your family or your ancestors came to the United States? Briefly, what was the story?

3. Are there any foods that you or someone else prepares that are traditional for your country(ies) of origin? What are they?

4. Are there any celebrations, ceremonies, rituals, holidays that your family continues to celebrate that reflect your country(ies) of origin? What are they? How are they celebrated?

5. Do you or anyone in your family speak a language other than English because of your origins? If so, what language?

6. Can you think of one piece of advice that has been handed down through your family that reflects the values held by your ancestors in the country(ies) of origin? What is it?

BELIEFS, BIASES, AND BEHAVIORS

1. Have you ever heard anyone make a negative comment about people from your country(ies) of origin? If so, what was it?

2. As you were growing up, do you remember discovering that your family did anything differently from other families that you were exposed to because of your culture, religion, or ethnicity? Name something that you remember that was different.

3. Have you ever been with someone in a work situation who did something because of his or her culture, religion, or ethnicity that seemed unusual to you? What was it?

   Why did it seem unusual?

4. Have you ever felt shocked, upset, or appalled by something that you saw when you were traveling in another part of the world? If so, what was it?

   How did it make you feel? Pick some descriptive words to explain your feelings.

   How did you react?

   In retrospect, how do you wish you would have reacted?

5. Have you ever done anything that you think was culturally inappropriate when you have been in another country or with someone from a different culture? In other words, have you ever done something that you think might have been upsetting or embarrassing to another person? What was it?

   What did you do to try to improve the situation?

IMAGINE

1. If you could be from another culture or ethnic group, what culture would it be?

   Why?

2. What is one value from that culture or ethnic group that attracts you?

3. Is there anything about that culture or ethnic group that concerns or frightens you? What is it?

4. Name one concrete way in which you think your life would be different if you were from that culture or ethnic group.

MYTHS FOR DISCUSSION (Source: Kavanagh & Kennedy, 1992).

1. It is a myth that educated and professional individuals do not have minority status problems or involve themselves in such issues.

2. It is a myth that personal concern with social stratification issues implies immaturity and non-professionalism.

3. It is a myth that institutions must adapt to the needs of minority groups or individuals, rather than minorities adapting to social institutions.

4. It is a myth that you can "get the feel" or "sense" of another culture without having to learn about its social organizations and social processes.

5. It is a myth that health care providers cannot be reasonably prepared to handle cross-cultural and other situations involving diversity because health care personnel in the United States deal with people from more than 100 ethnic, racial, and cultural groups.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

POST-UNIT EVALUATION

UNIT COVERED: ______

DATE__________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? ______ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

UNIT 7
CULTURAL DIVERSITY/ETHNICITY AMONG FAMILIES
UNIT TEST (10 POINTS)

I. TERMS (6 POINTS)

Match the terms with the correct meanings.

________ 1.	Culture	A.	Aunts, uncles, kin
________ 2.	Ethnicity	B.	Personal beliefs, values different from another person
________ 3.	Culture Shock	C.	Family born into or adopted into
________ 4.	Extended Family	D.	Shared beliefs, values, behaviors
________ 5.	Family of Origin	E.	An ethnic group
________ 6.	Hispanic American	F.	Race, or common geographic origin of group or people

II. LIST AT LEAST 4 STRATEGIES THE PSS CAN USE WHEN WORKING WITH ETHNICALLY DIVERSE FAMILIES (4 POINTS)

____

____

____

____

____

____

Unit 8
POSTPARTUM CARE AND PLANNING

The birth of a baby causes a great deal of physical and emotional change. It is a period of adjustment for every member of the family. Feelings of exhilaration, excitement and joy as well as frustration and the "blues" are all normal. Like the birth experience, each postpartum experience is unique. This unit focuses on the importance of helping clients take care of themselves – as well as their babies – during this special time and on the need to begin to make realistic decisions about their future.

Objectives

By the end of this unit, participants will be able to:

- Explain the postpartum vaginal discharge and other postpartum symptoms.
- Describe any postpartum symptoms that are dangerous.
- Define "baby blues" and postpartum depression.
- Give three suggestions for dealing with the "baby blues."
- Demonstrate how to talk to clients about making decisions for their future.
- Describe key points to cover when discussing postpartum diet and exercise.
- Name at least three concerns of postpartum women regarding resuming sexual relations.
- Give three reasons why a woman should go for a postpartum check-up.
- Describe at least two ways parents can help siblings adjust to the arrival of a new baby.
- Describe strategies for involving fathers in infant care.
- Explore ethnic/cultural beliefs about postpartum recovery and care of the newborn.
- Discuss regular periodic care and discuss use of emergency room for primary care.
- Explore barriers in communication between mothers and healthcare providers.

Time

6 hours

Outline

A. Postpartum Changes in a Women's Body
B. Postpartum Depression
C. Postpartum Diet and Exercise
D. Postpartum Check-up
E. Resuming Sexual Relations: Protection Against Pregnancy and Sexually Transmitted Diseases
F. Involving Fathers
G. Helping Siblings Cope with a New Baby
H. Planning for Your Baby's Healthcare
I. Planning for the Future
J. Communicating With Healthcare Professionals
K. Summary and Review

Adapted with permission from Resource Mothers, 1993.

Materials:

- Picture of father with children for discussion on how to involve fathers
- Resource Mothers. (1993). Handbook. Sterling, VA: INMED.
- Postpartum Home Visiting Guide **(Handout #1)**
- Things to watch for in the days after birth **(Handout #2)**
- Suggestions for dealing with the "baby blues" **(Handout #3)**
- Postpartum Home Visit Case Study **(Handout #4)**
- Goals for Myself **(Handout #5)**
- Role Play Scenarios **(Training Aid #1)**
- Role Play Feedback **(Overhead #1)**
- Post-unit Test
- Post-Unit Evaluation
- Newsprint, tape and markers, or blackboard and chalk
- Video equipment: video camera, tripod, tape, VCR, and television
- Video "What Lilly Learned – Immunizations" , Altshul Group, Evanston, Ill 60201

Advance Preparation:

- Read the *Resource Mothers Handbook*, Chapter 10, "Concerns of the New Mother."
- Assign this chapter to trainees as background reading.
- Collect pictures of fathers with babies
- Create appropriate role plays to use in practice sessions.
- Make sufficient copies of handouts.
- Try out video equipment. Set up video equipment to record role play and show prerecorded video.

A. POSTPARTUM CHANGES IN A WOMAN'S BODY (1/2 hour)

Rationale: New mothers experience many physical and emotional changes after the birth of a baby. PSS' can help new mothers cope with the changes by sharing with them what to expect.

Procedure: 1. **Mini-lecture and discussion.** Remind participants that taking good care of themselves and paying attention to signals from their bodies is just as important for their clients in the postpartum period as during pregnancy. **Postpartum** refers to the time after the birth of a baby when the mother is recovering from the birth. There is physical recovery which refers to the woman's body returning to its pre-pregnancy state including breasts, uterus, abdomen and weight. Psychological or emotional recovery has to do with mood stabilization as hormones return to normal levels and the mother adapts to having the new baby. Review with participants the physical changes that a woman experiences in her body the first 24 hours and the first weeks postpartum, ask participants if they remember how they, or a friend or family member, felt physically after delivering a baby. Have someone write these physical changes on newsprint so that you will be able to discuss them as a group and to be sure you cover all the points. Leave room on the newsprint under each item for tips on self-care for the new mother. Participants may refer to Chapter 10 in the *Resource Mothers Handbook* for additional ideas. Examples of **possible responses** follow. Add any that are not mentioned.

- Vaginal discharge (lochia) lasts 1-6 weeks. It is red to dark red at first and gradually turns pink and then to a yellowish or white discharge. It may have a mild odor.
- Cramps or afterpains that feel like a menstrual cramp.
- Discomfort from an episiotomy or bruising.
- Hemorrhoids or constipation.
- Breast engorgement (fullness and hardness felt when milk first comes in).
- Exhaustion from the work of labor and taking care of the new baby.
- A woman who delivered by cesarean section may have pain at the incision site and extra soreness.

Ask participants what information and practical tips would they give to their clients for taking care of their healing bodies. What is done in the community or in the culture to help women in the postpartum period? Are there any special customs or traditions? Have a volunteer write them on the newsprint next to the points above. Some **possible responses** include:

- Keep the vaginal area clean. Change pads each time you use the bathroom, then less often as the amount of lochia decreases. Do not use tampons. Take "sitz" baths to relieve soreness and to keep the area clean.

- Cramps are a sign that the uterus is decreasing in size and returning to its pre-pregnancy state. A woman who is breastfeeding her infant will notice that the sucking of the baby helps make the uterus contract. This is a good sign and should not cause concern. Try breathing and relaxation exercises to lessen the discomfort.
- Hemorrhoids are varicose veins in the anal area and are common during pregnancy and after delivery. Sitz baths can help relieve discomfort. Eating lots of fresh fruits and vegetables and drinking plenty of liquids, especially water, will help keep stools soft and avoid constipation.
- Don't overdo it. Get as much rest as possible. Sleep when the baby sleeps. Limit the number of visitors. Ask a family member or friend to come stay with you for a few days to help out.
- Apply warm towels to sore or engorged breasts. Take a warm shower. Express some milk. Wear a supportive bra, even at night while sleeping.
- A woman who had a cesarean delivery has just had surgery and her recovery period will be longer and slower.

Review **Handout#1** Postpartum Home Visiting Guide. This can help PSS remember what information is important to obtain from the mothers.

2. Participants can help clients recognize the signs of trouble in their bodies and the need to get plenty of rest. There are some dangerous physical signs that could mean a serious infection. A woman should call her health care provider if she experiences any of these signs. Ask participants if they know these signs. Add any of the following that they do not mention. Have someone write them on newsprint with a red "warning" magic marker. Also refer to **Handout #2**.

- A temperature of 100 or more
- Painful urination
- Breasts that have a red, warm, painful sore
- Increased vaginal bleeding or discharge that is heavier than a normal period. Passing a clot that is as large as your hand
- Vaginal discharge with a strong, bad odor
- No bowel movement for three days
- Constant, severe pain in the lower abdomen
- Hot, red, painful spot on the legs

3. Review the section in the *Resource Mothers Handbook* on how to take a temperature. If appropriate, have a few mercury thermometers available for practice taking and reading a temperature.

B. POSTPARTUM DEPRESSION (20 minutes)

Rationale: The "baby blues" are a natural reaction to the stress and tension that a big change, like having a baby, means to one's life. It is also due to hormonal changes after birth. There are times when "baby blues" become much more severe. PSS' must be able to identify when a new mother may need professional help.

Procedure: 1. **Exercise.** "Baby blues" peaks at 5-7 days. Begin by asking trainees to remember the emotions and exhaustion of those first days when they were home from the hospital with their first baby. How did they feel? Write all responses on newsprint. **Possible responses** are:

- Alone and scared in their new role as mother
- Exhausted
- Too much help from family members; just wanted to be alone with their baby

Were all their feelings positive? Why or why not? What is meant by the "baby blues" or postpartum depression? Is there a difference?

Discuss that "baby blues" can be caused by many things including being overwhelmed by new responsibility, lack of sleep, and hormonal changes after birth.

Distribute **Handout #3**, suggestions for dealing with the "baby blues." In small groups of three or four, have trainees brainstorm other suggestions they would give their clients to beat the "baby blues." These might include things mothers in your community can do or things your program might do. After a few minutes, come back together. Ask a spokesperson from each small group to share with the whole group one suggestion she thought was particularly good. Repeat this rotation until everyone has contributed.

2. **Group discussion.** There are times when the "baby blues" become much more serious. What is the difference between baby blues and postpartum depression? Work together on a definition, such as: Postpartum depression (or any kind of depression) is a serious loss of interest or pleasure in all or almost all usual activities and pastimes.

Ask participants if they have ever had close contact with someone suffering from depression. What are some of the signs they might see in a client suffering from postpartum depression? Add any of the following **possible responses** that they do not bring up:

- Sleep problems, both having trouble staying asleep and sleeping too much
- Staying in bed all day

Adapted with permission from Resource Mothers, 1993.

- Physical signs like headaches, stomach problems, weight gain
- Abuse of alcohol or other drugs
- Feelings of hopelessness
- Talk about suicide
- Unable to concentrate
- Feelings of worthlessness and guilt
- Easily annoyed
- Withdrawing from relationships
- Lack of concern for baby
- Concern they may harm the baby
- Lack of appetite

Postpartum depression often constitutes a medical emergency. Go over the steps a participant should follow if she suspects a client in your program is suffering from postpartum depression, or if she has indicated she is thinking about suicide. Depending on your program, these might include:

- ✓ Talk it over with your supervisor. Decide together on a plan of action.
- ✓ Help the client make an appointment with a mental health counselor.
- ✓ Help the client get to an appropriate support group meeting.
- ✓ Give the client hotline telephone numbers to call if she thinks she may hurt herself or her baby.

C. POSTPARTUM DIET AND EXERCISE (20 minutes)

Rationale: Many women will have questions and concerns regarding what activities they can resume after giving birth. PSS can help guide their decisions.

Procedure: 1. **Discussion and Group Exercise.** Ask participants whether they remember wanting to diet or exercise after their babies were born. Also ask them whether they think their clients will want to diet or do postpartum exercises. Why do they think this is so? What, if any, cultural taboos on exercise or leaving the house exist for the client? What should they tell their clients about postpartum nutrition and exercise? Points to cover or bring up if the group does not mention them:

- ✓ Women need their strength and really should wait a few weeks before they diet. Breastfeeding women do not need a diet to lose weight. But they need to eat a variety of nutritious foods and avoid empty calories. Their bodies need more of the same healthy foods they ate during their pregnancy, but they should not worry about gaining weight.

Adapted with permission from Resource Mothers, 1993.

✓ Exercise helps contribute to feeling of well-being. Exercise aids in healing and increasing strength. Kegels help tone and strengthen the vaginal and surrounding muscles. [If you need more information, refer to the *Handbook*.] Abdominal exercises help tighten the tummy and bring back the waist line.

2. Ask each trainee to work with a partner and jot down their ideas for encouraging their clients to eat well and exercise. Then ask each team to share one idea they think will be helpful. Ask a volunteer to write ideas on newsprint. Remind trainees that at the end of Chapter 10 in the *Handbook*, there is a place where they can write any suggestions that they would like to be able to share with their clients. Some **possible responses** for helping a client might be:

- Help plan or prepare a healthy meal with a client during your visit.
- Suggest that when a client does have time to cook, she prepare a casserole dinner and then freeze half of it for another meal later on in the week.
- If the weather is nice, go for a stroll with the baby during your visit.
- Spend a few minutes doing exercises.

D. POSTPARTUM CHECK-UP (15 minutes)

Rationale: Many women don't realize the importance of the postpartum check-up. Parenting Support Specialists can encourage women to seek this health care service.

Procedure: 1. **Brainstorming and discussion.** A postpartum check-up is generally scheduled about six weeks after a baby is born and sooner if a woman has had a cesarean birth. Ask participants if they think it is important for a woman to keep this appointment. Why or why not? What ideas can they brainstorm to encourage a woman to go to her postpartum check-up. **Possible responses** might include:

- Every woman wants to make sure she is healing properly.
- She will have a chance to discuss options and make a decision about a birth control method to avoid or delay another pregnancy.
- She can discuss any concerns she has about resuming sexual relations.
- In some clinics, the baby can be seen and possibly immunized before or after her appointment.
- It is a good way of proving to herself that she matters and she is worth this special effort.
- Discuss questions she may have about her labor and birth.

Adapted with permission from
Resource Mothers, 1993.

2. Review with participants any other things that will happen at this checkup. For example: blood pressure reading, PAP smear, check the uterus for firmness, check any problems that may have developed during pregnancy like varicose veins or hemorrhoids.

E. RESUMING SEXUAL RELATIONS: PROTECTION AGAINST PREGNANCY AND SEXUALLY TRANSMITTED DISEASES (15 minutes)

Rationale: Often women are afraid to ask questions they have about when they can resume sexual relations and what it may be like. Parenting Support Specialists can help clarify concerns and encourage healthy practices.

Procedure: 1. **Group discussion.** What questions do you think your clients might have about resuming sexual relations? What things do you think they may be worried about? **Possible responses:**

- Postpartum vaginal discharge taking a long time to go away
- Pain during intercourse
- The baby interrupting sex
- Having to wait to have sex until after their six week checkup
- Getting pregnant again
- Getting a sexually transmitted disease
- When will their menstrual period come back
- Breasts "leaking" during sex
- Feeling too tired for sex

There is information that the PSS can provide on all these topics. Ask participants how they might start a conversation about resuming sexual relations. What information and help can they provide to ease their clients concerns? **Possible responses:**

- ✓ Women who do not breastfeed can expect their menstrual cycle to return within six to twelve weeks after delivery.
- ✓ Women who are breastfeeding may not get their period again until their child starts eating solids (sometime between four to six months of age) or until they stop breastfeeding.
- ✓ A woman can get pregnant even before she has had her first menstruation after pregnancy so a client should use contraceptive protection.
- ✓ If her partner has an STD, she will expose herself to it unless she uses the right protection. PSS' should encourage the client to have her partner get treated.
- ✓ Take the first sexual encounter after the baby is born slowly. Don't do anything that feels too uncomfortable. Use K-Y jelly to help with lubrication if you are breastfeeding or real sore. The soreness will go

away with time – maybe up to six months. Wait until after the postpartum bleeding has stopped before you have sex to avoid any possibility of getting an infection. If possible, wait to have sex again until the six week check-up so that you can discuss contraception with your health care provider and be checked to be sure that you have healed well. If you are having sex before you see a health care provider, be sure and discuss family planning options with your PSS. [**Note:** Family Planning is covered in detail in Unit 9.]

F. INVOLVING FATHERS (20 minutes)

Rationale: Fatherhood is a major change for men and they too need support and attention. PSS can help fathers adjust to their new role.

Procedure: 1. **Discussion and activity.** Show participants the pictures of fathers playing with their babies. Ask them what they think of the pictures. Are they realistic? Why or why not? Ask if they think it is important for fathers to be involved with their babies. Why or why not? Ask each participant to select a partner and come up with suggestions to help their clients involve fathers in the care of the child. They should also think about suggestions for – and the feelings of – women who are single mothers. Should the father of their baby or another male in their family also be involved in care, nurturing and support? Ask participants to use ideas based on their own experiences. After five minutes have them come back together and rotate sharing ideas from each group that they think will be most helpful or relevant for the women with whom they will work. Here are some **possible responses** and points for discussion.

✓ Allow fathers time to learn how to take care of their babies. Sometimes it is hard for a mother to resist looking over his shoulder and telling him "the right way" to diaper or feed the baby. No one likes having someone look over his or her shoulder when trying something new; fathers are no exception to this rule. They need to learn by doing?

✓ Parenting Support Specialists can try to schedule the postpartum home visit at a time when the father is home too. Remember to address both parents during the meeting, not just the mother. Have some questions prepared just for the father. Ask him how he is adjusting to sleepless nights to sharing his wife with new baby or to learning how to change a diaper or bathe the baby. Find out what advice he has for other new dads.

Adapted with permission from Resource Mothers, 1993.

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- ✓ Fathers can burp the baby, change diapers, give the baby baths, and take the baby for walks to give the mother a break.

Possible responses for working with a single mom:

- ✓ It is okay to ask her how she is feeling about the baby's father. This will give her a chance to express her concerns, if any, about the father's involvement or absence.
- ✓ A single mother can ask for and get more help and support from family members and friends in caring for the baby.
- ✓ A single mother can try to get male family members to care for and work to establish close relationships with her children.

G. HELPING SIBLINGS COPE WITH A NEW BABY (10 minutes)

Rationale: Depending on their age, children will react differently to the arrival of a new baby brother or sister into the family. PSS can help families adjust to the arrival of a new member.

Procedure: 1. **Discussion.** Ask participants to share their or their friends' or family members' experiences with bringing a new baby home to older children. Did they have a hard time at first? How did they handle any problems that came up?

Chapter 10 of the *Handbook* has a list of suggestions for involving other children in welcoming the new baby home. Ask participants if they can add to this list from their own experiences with their families. Tell them they can photocopy this list to share with those program clients who have another child/children at home.

H. PLANNING FOR YOUR BABY'S HEALTHCARE (3/4 hour)

Rationale: Mothers need to know the reasons for establishing a primary medical care source for her baby and herself.

Procedure: 1. Review the advantages of a regular healthcare provider.
-Improves health between babies.
-Focusses on overall health and not just pregnancy health.
-Includes breast and gynecological examinations.
-Includes PAP test.

Adapted with permission from Resource Mothers, 1993.

2. Review the schedule for well-baby visits for the infant.
-Review the American Pediatric Association's guidelines for immunization and any other well baby checks. Include information through 16 years.

3. Review the importance of immunizations.
-Prolong life
-Prevent disease/infection
-Promote growth and development
-Promote wellness of the community

I. COMMUNICATING WITH HEALTHCARE PROFESSIONALS (1 hour)

Rationale: One of the barriers to health care may be the parent's hesitation with open communication with healthcare professionals. Improved knowledge and practice may improve communication.

Procedure: 1. A pediatrician or nurse will present on health awareness for parents of newborns. He/she will discuss the information the professional needs to be provided by mothers in order to support the family's health care needs.

2. Discussion of barriers to healthcare providing that result in negative perceptions of mothers.
-Moms may be uncomfortable and the office or clinic may not be a friendly place.
-Mom may have had a bad experience previously.
-Mom may not give appropriate eye contact.
-Mom may be very different from the healthcare provider (ie. poorer. less educated, less articulate) and therefore hard to understand.
-Moms may be dealing with many uncertainties (ie. money, food, home) and not able to fully concentrate on baby's care; this can be frustrating to the healthcare provider.
-There may be a conflict between patient priority and healthcare provider priority.
-Mom may have a lack of knowledge about he health care system and how it works.
-Moms may not have enough money, have problems with transportation and anticipate long waits.
-Providers may be busy, not pleasant and not aware of the various factors in the moms' lives.
-Providers may not have an understanding of cultural beliefs and practices.

3. PSS will engage in role plays to improve strategies in communication with healthcare providers. use **Training Aid** #2
Include the following strategies into the role plays:

Adapted with permission from Resource Mothers, 1993.

-Make up your mind to talk openly to your healthcare provider
-Practice describing your concerns so that the provider can understand.
-Recognize that you know yourself and your baby better than anyone.
-When you talk about your baby, be able to describe her eating and sleeping patterns, what her crying is like, what calms her. If she is sick, be ready to give her temperature, describe the symptoms and how long she has had these and be ready with the questions you have. Many people write these down because it is hard to remember everything.

4. PSS will review reports of infant physical exams and growth charts and discuss their meanings.

J. PLANNING FOR THE FUTURE (1/2 hour)

Rationale: There are many decisions that a new mother has to make for herself and for her baby. PSS's can help clients problem-solve and plan for the future.

Procedure: 1. **Discussion and Exercise.** Can I find someone to watch my baby so I can go back to school or work? Can I find a job with flexibie hours? How can I involve my baby's father in the care of my baby? Ask participants to describe some of the hard decisions or choices that they faced after having a baby and how they resolved them. Distribute **Handout #4**, Postpartum Home Visit Case Study. Have participants pair up. Share responses with the group.

2. Distribute **Handout #5**, Goals for Myself. Have participants practice helping a "client" solve problems and make decisions about her future. Explain that they also can use this form when making a postpartum home visit. It is one way to help a client begin thinking about her future. In groups of two, have each participant take turns helping her "client" fill in the handouts. Have them use an example of a tough decision that they themselves – or someone close to them – faced after having a baby. After the PSS helps her client work through a problem, give the trainees some time to share with each other how they solved their real life problem.

3. After everyone has had a chance to share and help solve a problem, bring the group back together. Ask participants to share how their partner solved a difficult problem. Use this opportunity to give each other a pat on the back for making what can often be some of life's most difficult decisions.

4. Ask participants if they found filling out the form helpful. Will it be helpful to clients? Why or why not? Would they change it in any way to make it more useful to their clients?

Adapted with permission from Resource Mothers, 1993.

K. SUMMARY AND REVIEW (10 minutes)

Procedure:

1. Go around the group and first ask each person to say one thing they have found useful or one thing they would like to know more about from this unit. Next time around, ask them to say one thing they have changed their mind about, or something they did not like about the Unit (and why).

2. Return to the objectives. Review them and make sure that the group feels that they have met the objectives for the Unit.

3. Have participants complete the post-unit evaluation form.

4. Distribute post-unit test.

Adapted with permission from
Resource Mothers, 1993.

POSTPARTUM HOME VISITING GUIDE

Here are some questions you may want to ask your "client" during the first postpartum hospital or home visit.

Tell me about your labor? What was your delivery like?

How are you feeling?

How are your stitches healing?

What's the blood flow been like?

How is the baby nursing?

What are your concerns?

Have you been finding time to eat?

What have you been eating? Are you getting WIC or Foodstamps?

Have you been finding time to take naps?

Who has come to visit?

Who has been helping with the baby? How does that work out? (Listen for mother's feelings of being left out, insecure, overwhelmed. Reinforce evidence of attachment, coping.)

Adapted with permission from
Resource Mothers, 1993.

THINGS TO WATCH FOR IN DAYS AFTER BIRTH

- A temperature of 100° or more
- Painful urination
- Breasts that have a red, warm, painful sore
- Increased vaginal bleeding or discharge that is heavier than a normal period. Passing a clot that is as large as your hand
- Vaginal discharge with a strong, bad odor
- No bowel movement for three days
- Constant, severe pain in the lower abdomen
- Hot, red, painful spots on the legs

SUGGESTIONS FOR DEALING WITH THE "BABY BLUES"

Here are some suggestions from other women for getting rid of "the blues".

- Talk to a friend about what troubles you.
- Take time out for yourself - every day, even if it is only ten minutes. Ask friends/relatives to help.
- Go outdoors for some fresh air, even if for just a few minutes.
- Make an effort to talk to others you meet. Try to meet with other new mothers, children, store clerks, older people, neighbors, etc. A smile and "hi" go a long way.
- Visit a friend.
- Ask for help taking care of the baby and/or family.

Adapted from: Expanded Food and Nutrition Education Program (EFNEP), Mississippi Cooperative Extension Service, "Partners for Life: A Maternal and Infant Nutrition and Health Curriculum," Mississippi State University, Mississippi.

POSTPARTUM HOME VISIT CASE STUDY

It has been 3 months since Misha's baby boy Martin was born. When you walk into her apartment, you are surprised to find Misha's boyfriend Lenny there also. After he leaves, Misha tells you that he just started dropping in a few days back, and now he's pressuring her to spend time with him again. She feels confused–she wants to make the relationship work, but she can't just leave the baby Martin alone and go off with Lenny. Also, she's worn out by all the demands that the baby **and** her boyfriend are making on her. "No-one's ever satisfied," she says. "They always want more. Anyway, where was Lenny when I needed him a few months back?"

Discussion Questions:

1. Why is Misha feeling confused?

2. Is she also feeling stressed? What signs do you have that she feels stressed?

3. How can the PSS help her sort out her concerns and decide on some specific steps to take?

   Some issues to be resolved include:

   Misha's relationship with her boyfriend.

   Has she discussed with him her anger over his absence from her life these last few months? Should she? What can she say?

   How can she satisfy the demands of the baby and still have time for her boyfriend?

4. If you were Misha's PSS, what would you say/do/advise?

GOALS FOR MYSELF

My plans for my education are:

In three years, I would like to see myself:

The kind of life I would like to have is:

The size family I would like to have is:

Adapted with permission from Resource Mothers, 1993.

After my baby is born I would like to:

It is important to me because:

In order to do this, I will have to:

It might be difficult because:

Adapted with permission from
Resource Mothers, 1993.

People I can ask for help are:

People who can help me with child care are:

I will know I have succeeded when I:

Adapted from: Expanded Food and Nutrition Education Program (EFNEP), Mississippi Cooperative Extension Service, "Partners for Life: A Maternal and Infant Nutrition and Health Curriculum," Mississippi State University, Mississippi.

ROLE PLAY SCENARIO

HAVE EACH PSS TAKE A TURN BEING A CLIENT AND A HEALTH CARE PROVIDER.

CLIENT #1

You are feeling well after the birth of your eight pound baby girl, Darla. Let you health care provider know that your sister has been helping you a lot with your meals and doing the wash. Here are some questions that you have been wanting to ask your health care provider...How long will discharge last? When can I have sex with my boyfriend again? I am feeling sore and it hurts when I wipe myself. Do I have to wait until my check-up? Will it hurt?

CLIENT #2

You have been feeling down since the birth of your second baby, Nicholas. Tell your health care provider that you feel achy after your long labor and it seems like you'll never get enough rest since your two-year old has been demanding so much attention all of the sudden. "Everything seems so noisy; I can't stand all the racket." Act sleepy and frustrated. When your health care provider gives you ideas for coping, be hopeful.

CLIENT #3

You are out of it. Your premature baby boy, Antonio, has been screaming for three hours. Then you screamed at him too and that only made things worse. You have a headache and you feel like everything is hopeless. You feel guilty that Antonio was born premature and you just don't feel up to taking care of him. You also had a fight with your mother and told her not to come around because you don't want her help. You don't know what to do, you feel so desperate. You should see your health care provider. What can you say to your health care provider so that you will get some help?

Adapted with permission from
Resource Mothers, 1993.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

Adapted with permission from
Resource Mothers, 1993.

POST-UNIT EVALUATION

UNIT COVERED: ______

DATE__________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? ______ If not, please explain.

Adapted with permission from Resource Mothers, 1993.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

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UNIT 8
POST-UNIT TEST
POSTPARTUM CARE AND PLANNING

INDICATE WHETHER EACH STATEMENT OR SITUATION IS TRUE (T) OR FALSE (F).

____ 1. The postpartum period is the time a woman recovers from childbirth and she and her family adjust to the new birth.

____ 2. It is possible for a woman to become pregnant during the 6 weeks following the birth of her baby.

____ 3. During the postpartum period a woman who has a prolonged loss of appetite may be depressed.

____ 4. The "baby blues" is a temporary type of postpartum depression.

____ 5. Ms. Smith states that she is constipated, so the PSS should tell Ms.Smith to but a laxative and use until her bowel movements return to her normal pattern.

____ 6. Ms.Wolf is breastfeeding and she tells the PSS that she is feeling more afterpains than her friend who is not breastfeeding. The PSS should tell her that this often occurs when a woman is breastfeeding her baby.

____ 7. Ms. Johnson tells the PSS that she is still passing blood clots and she needs to change her pad every hour. The PSS should tell the mother that this is normal during the postpartum period.

____ 8. Ms.Woods tells the PSS that it is really very painful when she urinates and she has to urinate very often. The PSS should tell Ms.Woods to call her doctor or clinic right away.

____ 9. Ms. Smalls tells the PSS that her 2 year-old daughter is asking to use a bottle like her new baby brother. The PSS should tell Ms. Smalls that she understands her concern and that she should call her child's doctor (pediatrician).

____ 10. Ms. Lake tells the PSS she has to return to her job in 3 months and that she is not sure if she can care for the baby, her other children and work. The PSS should try to help Ms. Lake set goals and list some ideas and ways she can meet her personal goals.

Unit 9
FAMILY PLANNING OPTIONS

This unit will help ensure that participants are provided with accurate and timely information so that, in their role as Parenting Support Specialist, they will be able to provide accurate information to clients about many aspects of family planning and contraceptive choices.

Objectives

By the end of this unit, participants will be able to:

- Understand that their own attitudes and perception about specific contraceptives will influence their clients attitudes and use of contraceptive options.
- Explain the reproductive cycle and when (and how) a pregnancy occurs.
- Explain how to use available contraceptive products.
- Discuss advantages and disadvantages of contraceptive products and methods, where they are available, relative costs, when they are not advised, and common and serious side effects.
- Explain why the same method is not appropriate for all women, or even for the same woman at different times in her reproductive life.
- Discuss safe sex in regards to STD/HIV.
- Discuss ways HIV is transmitted.
- Distinguish between HIV and AIDS.
- Explain HIV antibody tests.

Time

5 hours

Outline

A. Climate and Attitudes
B. Introduction/Definitions
C. Method Choice Exercise
D. Understanding and Explaining Available Contraceptives
E. Exercise on Helping Clients Make Family Planning Decisions
F. Ask the Expert
G. Practice Session: Providing Information to Clients
H. Summary and Review

Materials

- Resource Mothers. (1993). Handbook. Sterling, VA: INMED.
- AIDS Information **(Handout #1)**
- Reproductive Physiology **(Training Aid #1)**
- Case Study Scenarios **(Training Aid #2)**
- Role Play Feedback **(Overhead #1)**
- Oral Post-Unit Test **(Training Aid #3)**
- Post-Unit Evaluation
- Recent reference material and magazine and newspaper articles on one or more contraceptive products. Population Reports, Series J, No. 36, December 1987, and the chart on "Postpartum Contraceptive Methods" in Network, Vol.11,(No.3), August

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Adapted with permission from
Resource Mothers, 1993.

1990 are two reliable, comprehensive overviews. Should you wish to order copies of the material referenced above, Population Reports is available from the Population Information Program at Johns Hopkins University, Tel: 301-659-6300; Network is distributed without charge by Family Health International, Tel: 919-544-7040.

- Latest edition of Contraceptive Technology. N.Y.: Irvington Publications. (to order, call 603-669-5933).
- Video Equipment: video camera, tripod, tape, VCR, and television
- Video: "Playing It Safe: What Every Women Should Know" choosing a birth control method (SEARLE).
- "Name That Method" game contraceptive kit (Ortho).
- Newsprint, colored markers, and tape; chalkboard and colored chalk (multiple colors).

Advance Preparation:

- Read the *Resource Mothers Handbook*, Chapter 11, "Family Planning."

- Assign this chapter to participants and suggest they come to this session prepared to raise many questions.

- Invite an "outside expert," perhaps someone who counsels clients at a family planning clinic, to attend this session and be available to answer questions, clarify disputed points, and correct any misinformation.

- Read, or have available, the latest edition of Hatcher, R., et al, Contraceptive Technology 1990-1992. This is a thorough and complete manual, updated every few years, and targeted to health professionals.

- Ask the "outside expert" to bring samples of birth control methods to the class or call the local health department and explain you are teaching a class on family planning. Ask if they have samples of various methods that you could have as part of your display. You can also go to the drug store and purchase all the over the counter methods for Parenting Support Specialists to touch/feel/see.

- Cut up and fold the Case Study Scenarios for the exercise of helping clients make family planning decisions, **Training Aid #2**.

- Prepare additional handouts, and especially role play situations, as needed.

- Collect some client support materials on family planning (one or more methods) that trainees can use during their role play practice session.

- Try out video equipment. Set up camera to videotape role plays.

Adapted with permission from Resource Mothers, 1993.

A. CLIMATE AND ATTITUDES[1] (45 minutes)

Rationale: In order for PSS to feel more comfortable discussing family planning, it is important that they feel somewhat comfortable discussing sexual issues in general. The purpose of this "ice-breaker" exercise is for PSS to understand the impact of socialization practices on an individual's level of comfort/discomfort in discussing sexual issues, and how society discourages open communication about sexuality.

Procedure: 1. Ask the trainees to form groups of three.

2. Ask each person in the group to take one to two minutes to discuss this question: "What was the prevailing sexual climate and what were the prevailing sexual attitudes as you were growing up?

[**Note:** The content of those small group discussions will usually be that accurate information and open communication about sexuality was often lacking.]

3. Ask each person in the group to take another one or two minutes to discuss: "What are three messages you received as a child that might affect your ability to talk with a client about sexuality and family planning?"

4. Ask the trainees to discuss the next question, "What do you see to be the prevailing sexual climate and the prevailing sexual attitudes now, as young people are growing up; how is it similar/different; better/worse; harder/easier than when you grew up?

Suggest that participants expand the concept of "sexual climate and sexual attitudes" beyond that of simply reproduction or romantic/erotic, boy/girl issues, and focus on such topics as STDs, marriage and divorce, birth control and abortion, sexuality and the media, etc.

5. Large group discussion: ask the participants whether they think it is better or worse for people growing up now. How? What kinds of things are clients facing today in terms of sex and sexuality that are different or the same as the issues women and men faced a generation ago? How do these issues affect family planning choices?

6. Points to conclude with: in order to talk about sexuality and family planning it is important to recognize one's social, cultural and personal barriers to communicating about sexuality.

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[1] Adapted with permission from: Communication Strategies for HIV/AIDS and Sexuality, A Workshop for Mental Health and Health Professionals, A SIECUS Training Manual by: Diane de Mauro, PhD, Carolyn Patierno, Sex Information and Education Council of the United States, New York, 1990.

B. INTRODUCTION/DEFINITIONS (1/2 hour)

Rationale: Although Parenting Support Specialists will not be making specific recommendations for clients, it is important that they have a basic knowledge of family planning options so they can provide accurate information to clients for their decisions about family planning.

Procedure: 1. **Mini-lecture and discussion.** Find out what the words "family planning," "birth control," "contraceptives," "conception," "contraception," "informed choice," and "menstrual or reproductive cycle" mean to trainees. You may want to put some definitions on the board, so trainees can refer to them throughout this unit. You will probably learn that people use some of these terms interchangeably, and indeed their meanings are often synonymous, or at least very similar. Some points you – or the group – will want to cover follow.

✓ **Family Planning** means having the number of children you want when you want them. But "family planning" can also be used as a synonym for a contraceptive method, as in, "I am practicing family planning." In that case "family planning" refers to methods used by sexually active people to prevent or space births and thus attain their desired family size. The words "**birth control**" could be substituted for "family planning" in the preceding sentences without changing the meaning. Some people don't like the term "birth control," as it sounds as though someone is being forced to do something. **Contraceptives** are the methods and products one can use to prevent **conception** (the process of becoming pregnant). **Contraception** is the opposite of conception; it is the use of products or methods to prevent pregnancy. A family planning clinic or program is one that provides contraceptive products, as well as advice on methods and products (and often other aspects of reproductive health as well).

✓ Other terms used when discussing contraception are categories of methods: **hormonal methods, barrier methods, chemical methods, permanent methods,** and methods of **periodic abstinence or natural family planning.** Don't discuss all methods in detail here; that will be covered in section C. Just make sure these terms are understood, so there won't be confusion when trainees hear others use them. You can refer trainees to definitions in the *Resource Mothers Handbook*, Chapter 11, and in the Glossary.

✓ **The health benefits of family planning.** Many people don't realize that practicing family planning is good for the health of the new mothers and her infant. Ask why they think this is true (or untrue). **Possible responses** and discussion topics include:

Adapted with permission from Resource Mothers, 1993.

- It takes a woman's body two years to "recover" from one pregnancy and get ready for another one.
- Mothers will be healthier if they give their bodies a "rest" between pregnancies.
- Babies who are not born too close together are more likely to be healthy.
- Mothers (parents) have more time to spend with each child if they are spaced two or more years apart.
- Children may be emotionally healthier if they receive all the attention they need from their mothers (parents).
- The relationship between partners may suffer when they have closely-spaced babies and not enough time to spend together.
- Some barrier methods protect women from getting some sexually transmitted diseases (STDs).

✓ Discuss the term **informed choice** as it relates to family planning. Having a "choice" implies having alternatives or options for making decisions. Being "informed" means understanding what these choices or options are.

Informed choice means that a client makes a decision about having children after getting appropriate and correct information through many different channels. (PSS's have an opportunity to be one of these "channels." You may want to come back to this idea later on.) Clients must also have access to a variety of options. Informed choice means making a decision about family size, deciding whether to use family planning, and deciding **what** methods to use. [**Note:** You should refer back to the previous unit on postpartum planning, where trainees looked at ways to help their clients set postpartum goals for themselves. Point out that clients need to take their own goals and personal life situations into consideration as part of making an informed choice.]

Ask **why** informed choice is important. One **response** you are looking for: When women (and men too) have an opportunity to make their own decisions about family planning and spacing their children, they are more likely to be satisfied with their choice. Tell trainees that studies from around the world show that when people have an opportunity to choose to use a contraceptive method, and when that method is properly explained to them, they are more likely to do three things: (1) follow instructions accurately for using the method, (2) continue using some method of family planning over time, and (3) recommend family planning to friends and relatives.

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2. Before discussing, in depth, what people can do to control their own fertility, find out what trainees know about how conception occurs. See **Training Aid #1**, on reproductive physiology, for some key points that you may want to share with the group. Drawings are included, in case you wish to make a transparency for use when discussing both conception and contraception. There is **much confusion** as to **when** in a woman's monthly menstrual cycle she **can** get pregnant. Emphasize that this is because the exact day is different for different women, and even for the same woman in different months. All women should have some idea as to when they ovulate (when an egg is released). If a woman does not want to conceive, she must refrain from sexual intercourse during those days before, during, and after ovulation, or she (or her partner) must protect themselves by using contraceptives. In most women, ovulation occurs at mid-cycle, about 10 to 16 days before their next menstrual period.

3. Before beginning the next exercise, ask trainees when they think is a good time to discuss family planning options with their clients. **Possible responses** might include:

- anytime.
- following delivery.
- before deliveries.
- during the last trimester.

Discuss the pros and cons of their suggestions.

C. METHOD CHOICE EXERCISE (1/2 hour)

Rationale: This brainstorming activity is to identify all the methods and products used by American women (couples). The exercise that follows should demonstrate the fact that a PSS's perception of a family planning product or method can influence her clients perception and use of a method. This can have both positive and negative ramifications.

Procedure: 1. Begin by asking everyone to brainstorm all methods of family planning they have ever heard of. Have someone write out each method in large letters on 8 x 11 sheets of paper for future use. Be sure to include those practices that some consider family planning but that truly are not effective at preventing pregnancy.

2. **Exercise.** Break into groups of two or three. Use 'Methods' chart on pg.9-8. Cut apart. Distribute two or three methods to each group. For each method, ask the groups to list advantages and disadvantages. Give the groups 15-20 minutes to complete this exercise. Ask for one person in each small group to be the recorder and spokesperson.

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3. While the group is doing this, prepare a chart, like the one below, on the board or newsprint.

4. Go around the room and ask participants to name the method and one or two advantages and disadvantages. As they do this, ask for comments from all members of the small and large groups and record information.

5. As participants give their opinions, everyone should begin to note that, what is an advantage to one person may be perceived as a disadvantage to another. For example, one woman may like the birth control pill (combined oral contraceptives) because "there's nothing to remember at the time of sex," while another may say it's not desirable because you have to remember to take it everyday. Discuss the following questions with trainees:

- How may their perception of a family planning method influence their clients?
- What happens if PSS's are not aware of their own biases?
- How can a PSS present new information without letting personal preferences and biases affect the way the material is presented?

6. You should point out that this exercise complements some exercises on attitudes and values that trainees did during Unit 2. Some key points to emphasize:

✓ When educating and counseling clients, it is important to be aware of one's own values. If a PSS has a particular bias and cannot deal with an issue (for example, teen contraception), she should let her supervisor know so that someone else who may not hold the same bias can counsel the client.

✓ PSS's will want to avoid influencing clients on the basis of personal biases, and instead help people make their own decisions that are right for them.

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METHOD	ADVANTAGES	DISADVANTAGES
Condom		
IUD		
Norplant		
Depo Provera		
Birth control pill		
Barrier Methods: • Diaphragm • Cervical cap • Sponge • Spermicides		
Sterilization: • Tubal ligation • Vasectomy		

Adapted with permission from Resource Mothers, 1993.

D. UNDERSTANDING AND EXPLAINING AVAILABLE CONTRACEPTIVES (1-1/2 hours)

Rationale: Instead of having someone come in to lecture to participants about all available family planning (or contraceptive) methods, PSS' will remember more if they are involved in the compilation of the information. It is still a wise idea to invite an "outside expert" to come, not to lecture, but to mediate any discussions, settle disputes, and answer any questions that arise about a method or procedure.

Procedure: 1. **Team Activity.** Divide trainees into two or three teams, depending on the size of the training group. If possible, each team should have at least three members.

2. Give each team two or three large sheets of newsprint and two different colored marker pens.

3. Ask each group to share all they remember about two or three family planning methods. Without opening their *Handbook* or using other reference materials, each team will create a chart showing the advantages, disadvantages, contraindications, and the types of women (couples) who are good candidates for the methods they are covering. After they have written down all they remember, they can look to their *Handbook* or other material for help. But they should then change markers, so the information they add will appear on their chart in another color. This way you can have a little "competition" or contest at the end, by directing everyone's attention to the changes in ink color and determining which team had the greatest recall of accurate information prior to consulting any reference material.

4. Assign – or let teams volunteer for – the methods they will present. You want to make sure that all major methods are covered, so the number assigned to each team will depend on how many teams you have. Assignments should include: natural family planning methods, birth control pills, intrauterine device or IUD, Norplant, Depo-Provera (the new injectable), condoms, Today® sponge, diaphragm, spermicides, and sterilization.

5. When the teams have completed their charts, they will take turns presenting this information to the large group, explaining everything as they might explain these methods to clients. For variety, you might ask the spokesperson from one team to talk as though she was working with a teenager, another as though her client was a woman in her 30's with three children, another as though her client was a woman whose baby had just been born HIV-positive, etc. Be creative. There's much you and the trainees can do with all this wonderful information they have assembled.

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6. Be sure to advise trainees that no matter how much information on family planning they impart to their clients, they should also encourage them to discuss this topic further with their health care provider.

7. Ask your invited guest (the outside expert) to provide constructive feedback, pointing out any omissions and correcting any misinformation. Also encourage participants to ask your guest any questions they have about any aspect of available contraceptive choices. Use this opportunity to also discuss some related topics, such as:

✓ Abstinence. Should PSS's be promoting this with their unmarried clients? Why or why not? How can they make this alternative attractive to a single 15-year-old who lives with her mother, various siblings, and grandmother, and has given birth two months ago? Trainees might discuss the differences between sexuality and "sex," and how and why people (not just teens) confuse sex with love.

✓ Any methods that are "unsafe" because they really don't prevent pregnancies from occurring, such as withdrawal or douching with coke after sex. (Some people refer to these as "traditional" methods – as opposed to the others which are called "modern" methods. The group may want to discuss these terms, as well.) Refer trainees back to the list of contraceptive methods and products they brainstormed at the beginning of the last exercise. Review the list together and put a mark alongside all these so-called traditional methods. Ask your guest to comment further on **why** these methods don't work.

✓ Depending upon the interest level and questions of participants, you or your guest should also discuss the **safety and efficacy** of some of the more popular methods. Point out that the U.S. Food and Drug Administration (FDA) only approves new methods after they have undergone years of rigorous testing and have been proven safe. (Your guest may want to give some specifics from the recent hearings and approvals for Norplant and Depo-Provera.) But that doesn't mean that the same products are equally safe for all women; that's why trainees also pointed out contraindications when explaining each method.

✓ Make sure that someone mentions that using a modern family planning method is much safer (in terms of its effects on a woman's body and health) than having a baby. This is particularly true if the woman's pregnancy was unplanned and/or undesired. She is less likely to take proper care of herself and/or the fetus.

✓ When discussing efficacy, make sure someone explains the difference between **theoretical effectiveness and effectiveness under actual use conditions.** The former refers to the effectiveness of a product based on how scientific tests indicate the product should perform when used

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properly and consistently. The latter refers to how effective products are when actually used in real-life situations. For some methods, the two types of effectiveness are the same. (Examples would be tubal ligation and Norplant.) Ask the group why this could be so. With what products will there be the greatest differences in these two effectiveness rates? (Examples might be condoms and the pill.) Why? Discuss.

✓ The relationship between contraceptives and disease transmission. Point out to trainees that the basics are discussed in their *Handbook*. When a PSS is working with a client who thinks she may have been exposed to an STD, she will want to point out that testing is usually quick and painless, and that many STDs can be cured. However, prevention is always better than cure, and that's emphatically true for those STDs that have no cure such as AIDS (which is caused by a virus called HIV). AIDS kills. That's a fact, but there's also much misinformation about AIDS. Thus all participants need to know (1) how AIDS is spread and (2) how to avoid AIDS, so they can share this information with **all** their clients.

✓ Distribute **Handout #1**, AIDS information. Give participants a few minutes to read it, or read it together as a group. You or your invited guest may want to ask some questions to make sure trainees have absorbed the information. Suggest trainees may want to make copies of the handout to share with their clients.

✓ Review available support materials relating to family planning and HIV infection. [**Note:** leaflets and booklets on these topics prepared by the Center for Population Options and the Channing L. Bete Company are useful because they are clear and easy to read.]

✓ Discuss the relative cost of various contraceptive methods.

✓ Abortion. Is abortion a method of contraception? Why or why not? How much should a PSS tell a client who is pregnant and makes it clear that she does not want a baby at this time? Some clients may not know their rights, under both Federal and State laws. Is knowing where to refer, and doing so, the best role for the PSS? Discuss.

If the client does elect to have a first trimester abortion, how can the PSS help her deal with the feelings of guilt or sadness she may experience? What do trainees recommend, based on direct experience or the experiences of friends and relatives?

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E. EXERCISE ON HELPING CLIENTS MAKE FAMILY PLANNING DECISIONS (1 hour)

Rationale: PSS's are not trained to give out medical advice, but they need to have baseline knowledge to help women make informed choices. PSS's won't decide what are medical contraindications. They may help a woman decide what lifestyle factors make a choice less desirable.

Procedure: 1. Before this exercise begins, you should cut up and fold the various case study scenarios provided in **Training Aid #2** and make up additional ones based on the cultural norms of the community.

2. Explain that trainees are going to work together as a group and practice helping clients make appropriate family planning choices. Put folded case studies into hat and ask someone to choose one and read only the top part to the other participants.

3. Then ask the following questions, which you will want to put on newsprint or the board, as trainees will answer these same questions for each subsequent case study. Have trainees discuss them and arrive at some sort of consensus. **Questions:**

   a. What do you see in this situation?
   b. Is this person a candidate for a family planning method?
   c. Does she have contraindications for any methods? If so, for which methods? What choices are left to her?

4. When trainees have agreed on the above, point out that their clients will have heard of various methods, and may already have a particular method in mind. At the bottom of each case study is the method that this person plans to use. Ask the trainee reading the case study to read the last line; it tells which method the client has in mind.

5. Ask if the group feels that this method is appropriate for this client. If so, why? If not, why not? If the group feels that it is inappropriate, how would they explain this to the client and encourage her to use another method?

6. When trainees have finished discussing this case, ask another volunteer to select a case and, again, read only the top portion. Discuss the same questions as before. Then the trainee reads the client's choice, and the group discusses whether or not they agree, and how they would counsel the client. Repeat this process until all cases have been discussed (or until you feel that enough time has been spent on this exercise).

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7. Before proceeding, trainer should summarize this exercise by saying it points out that there is no "one best method" for all women (couples) at all times. Different methods are appropriate for people at different times in their lives. If any woman (trainees as well as clients) finds that one method is not pleasing to her, for any reason, then her health care provider can help her find another method that is more suitable. Point out that such "method switching" should not be discouraged. PSS's can help their clients find a family planning method that they will feel comfortable using and will use effectively. Answer any lingering questions, deal with any doubts, etc.

F. ASK THE EXPERT (1/2 hour or longer)

Rationale: Trainees may be shy about asking questions in particular about a topic like sex and family planning. This exercise provides an opportunity to ask "all you want to know, but were afraid to ask."

Procedure:

1. Distribute 2-3 index cards to all trainees.

2. Allow 5-10 minutes for each to write questions about sexuality, body functions, conception, family planning – anything!

3. Collect the cards.

4. Allow the PSS's to take a break – perhaps look over the contraceptive devices while you and the local expert categorize questions.

5. Come together as a group. Read aloud each question, have the expert provide the answer. Use visuals or support materials as often as possible.

G. PRACTICE SESSION: PROVIDING INFORMATION TO CLIENTS (3/4 hour)

Rationale: Participating in role plays will assist the PSS in integrating the information presented by putting it into 'real life' situations.

Procedure:

1. **Role plays.** Go around the room and ask trainees to count off: 1,2,1,2,1 etc. All the "1's" will begin this exercise playing clients and the "2's" will be the Parenting Support Specialists. After completing one role play, they will switch roles. Now ask each "1" to select a "2" as her partner. Preferably someone with whom she has not partnered with before. [**Note**: This is just a slight variation on the oft-repeated request to break into teams of two.]

2. Have each team role play two different scenarios, so each gets practice and gains experience advising and counseling a client. If possible,

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have someone video tape their efforts, so trainees can replay the tape at some other time, critique their own "performances," and discuss with their team mate how they might improve their message and/or communication techniques. Remind the group of all the exercises they have done on both verbal and non-verbal communication techniques. They should be practicing these skills whenever they are asked to interact with an imaginary client.

3. Ask each team to select two of the case study scenarios that were used in the previous group exercise. But this time, the PSS will advise and counsel the "client," who will base what she says on the information provided in the scenario. The person playing the PSS should use some appropriate support materials to reinforce her verbal messages.
4. Before they begin, ask trainees to review what kinds of information about contraceptive methods or products they want to give to the "clients." **Possible responses** should include:
    - What it is; how it works; types of persons for whom it's particularly well suited; how the method is used and what, if anything, the client has to remember to do; advantages; disadvantages; how effective it is in preventing pregnancy; contraindications.
5. Trainer – and the outside expert – should move about while teams are role playing, both to offer encouragement and to gently correct any misinformation.
6. If time allows, ask for volunteers to present one of their role plays to all the other trainees. When they finish, get comments and feedback from the others. Be sure to give everyone a big round of applause at the end of this session. They worked hard!

H. SUMMARY AND REVIEW (15 minutes)

Procedure:

1. Rephrase the objectives on the first page of this unit as questions and ask trainees to take turns answering them. For example: Who can explain why family planning is part of preventive health care for women? What do the PSS's attitudes and perceptions about family planning have to do with their clients, etc.?
2. Distribute post-unit evaluation forms for trainees to complete.
3. Begin the oral post-unit test **(Training Aid #3)**. Using this information, ask each participant about at least one family planning method. Have the questions they will be asked printed on a flip chart.

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AIDS INFORMATION

AIDS (Acquired Immune Deficiency Syndrome) is a deadly disease that is spread by sexual intercourse. Because family-planning clients are sexually active, they may be at risk of catching AIDS. Therefore, family planning clients need to know (1) how AIDS is spread and (2) how to avoid AIDS.

HOW AIDS IS SPREAD

Tell your clients:

- The main way a person gets AIDS is by having sex with someone who is infected with the AIDS virus.
- Most people who are infected with the AIDS virus do not look or feel sick. They may not know that they are infected. But they can still spread AIDS to others during sex.
- Men and women with genital sores or infections are more likely to catch AIDS or give it to other people.
- AIDS is also spread by blood or blood transfusions from people who are infected.
- Sharing any kind of dirty needles spreads the AIDS virus.
- A woman who is infected can give AIDS to her sexual partners and to any baby she has in the future.
- AIDS is not spread by kissing, touching, sharing foods or toilets, or taking care of a person with AIDS.

HOW TO AVOID AIDS

- To limit the number of sexual partners. The surest way to avoid AIDS is to abstain from sex. Another good way is to have sex with only one partner who is not infected and who has no other sexual partners.
- To use condoms all the time unless they are sure that they and their partner are not infected. (If it is possible as part of your program, give your client some condoms to try.) Condoms provide considerable protection against AIDS. Condoms and spermicides together are probably the best protection. No other family planning methods, including vasectomy, protect against AIDS.
- To use condoms to prevent AIDS even when they use other family planning methods to prevent pregnancy.
- To talk with their sexual partners about AIDS and agree on ways to protect one another from AIDS.

From: "Population Reports", Series J, Number 36, Population Information Program, The John Hopkins University, Baltimore, MD, December 1987.

Adapted with permission from
Resource Mothers, 1993.

REPRODUCTIVE PHYSIOLOGY

[Note to trainers: The information that follows is only the basics and supplements pages 193-194 of the *Resource Mothers Handbook*. Use what seems applicable for your group of trainees; augment the information, if needed, by using reference material such as Chapter Four of Hatcher et al, *Contraceptive Technology 1990-1992,* 15th Revised Edition, Irvington Publishers, Inc, New York, 1992. If a word in the following text is underlined, it means it is further defined at the end of the general description.]

Menstrual or Reproductive Cycle

The term **menstrual** cycle refers to the entire cycle of "physical changes from the beginning of one menstruation (day one of menstrual bleeding) to the beginning of the next. The reproductive or menstrual cycle is regulated by hormones. During a woman's childbearing years, monthly changes in the levels of hormones determine the timing of her ovulation and menstrual periods. This cycle prepares a woman's body for the possibility of pregnancy.

Each month one egg (or ovum) in the woman's ovaries matures. It makes the hormone estrogen, which causes the uterine lining to grow thick and rich in blood supply. Usually sometime between days 13 and 16 of the reproductive cycle, an ovary releases an egg into a fallopian tube.

If the egg is met and fertilized by a sperm, it implants itself into the uterine wall (called the endometrium). Hormones signal the uterine lining to secrete substances to nourish a fertilized egg and a fetus develops. If conception does not occur, the blood and tissue of the lining are then discharged. This is the menstruation (or the menstrual period). It lasts for about five days. Then a new ovum begins to mature and the cycle begins again.

Conception

During sexual intercourse a man deposits semen, filled with sperm, in the woman's vagina. The sperm pass through the cervix and the uterus (also called womb) and reach the fallopian tubes. There, if sperm encounter an egg, conception (pregnancy) can occur. If sperm do not reach and fertilize the egg, the egg passes through the woman's uterus and leaves the woman's body during her menstrual period.

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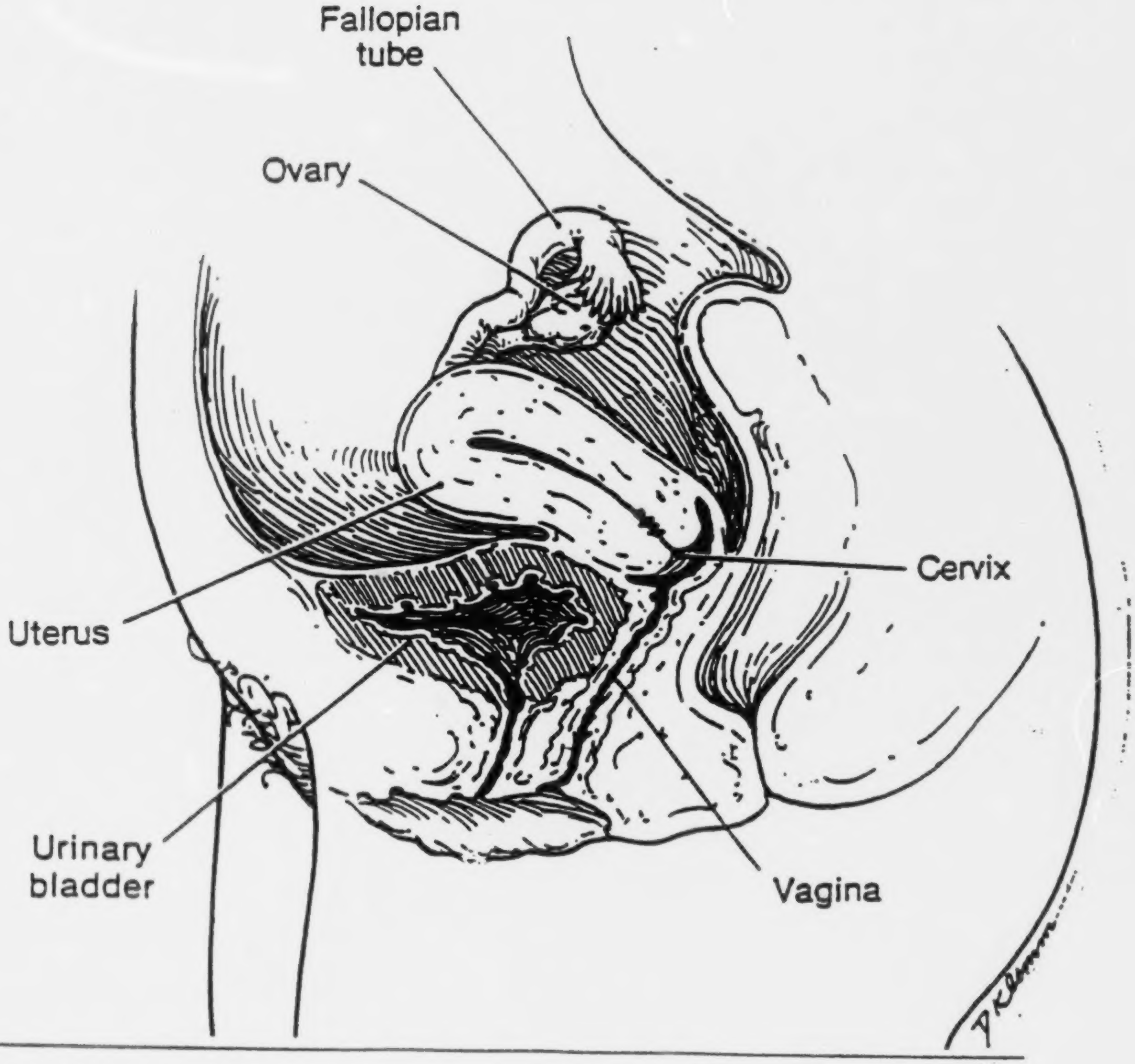
Vocabulary:

Ovulation:	The process in which the ovum (egg) is released from the mature ovary. Ovulation usually occurs 10 to 16 days before the next menstruation. The egg is capable of being fertilized for about 10 hours after ovulation, but probably no more than 24 hours.
Ovaries:	The female sex glands above the uterus that produce eggs (ova) and hormones that control female reproduction. (See Figures 1 and 2).
Fallopian tubes:	Two tubes that extend toward the ovaries from the upper sides of the uterus. After ovulation, the ovum (egg) passes from the ovary into the fallopian tubes. Following intercourse, sperm travel through the uterus and into the fallopian tubes, where fertilization normally occurs. The fertilized egg normally travels through the fallopian tube and implants in the uterus. (See Figures 1 and 2).
Fertilization:	The process of uniting the sperm and ovum (egg). Fertilization normally occurs in the fallopian tubes.
Implantation:	The normal process in which the fertilized egg becomes attached to the lining of the uterus (endometrium).
Sperm:	Mature male reproductive cell. Sperm are produced in the testicles, located in a man's scrotum (balls). Sperm (along with a fluid, semen) are ejaculated through the penis during intercourse.
Menstruation:	The cyclic discharge of the lining of the endometrium (menstrual blood, cellular debris, and mucus) that occurs about two weeks after ovulation if the woman is not pregnant. (Also called menses or period.)
Menstrual Cycle:	The number of days from the first day of menstrual bleeding. The cycle usually lasts from 22 to 35 days, but this may vary more for some women. Except when they are pregnant or postpartum, most women will menstruate (or have periods) from menarche (the time of first menstruation) to menopause (the end of menstruation).

Adapted with permission from
Resource Mothers, 1993.

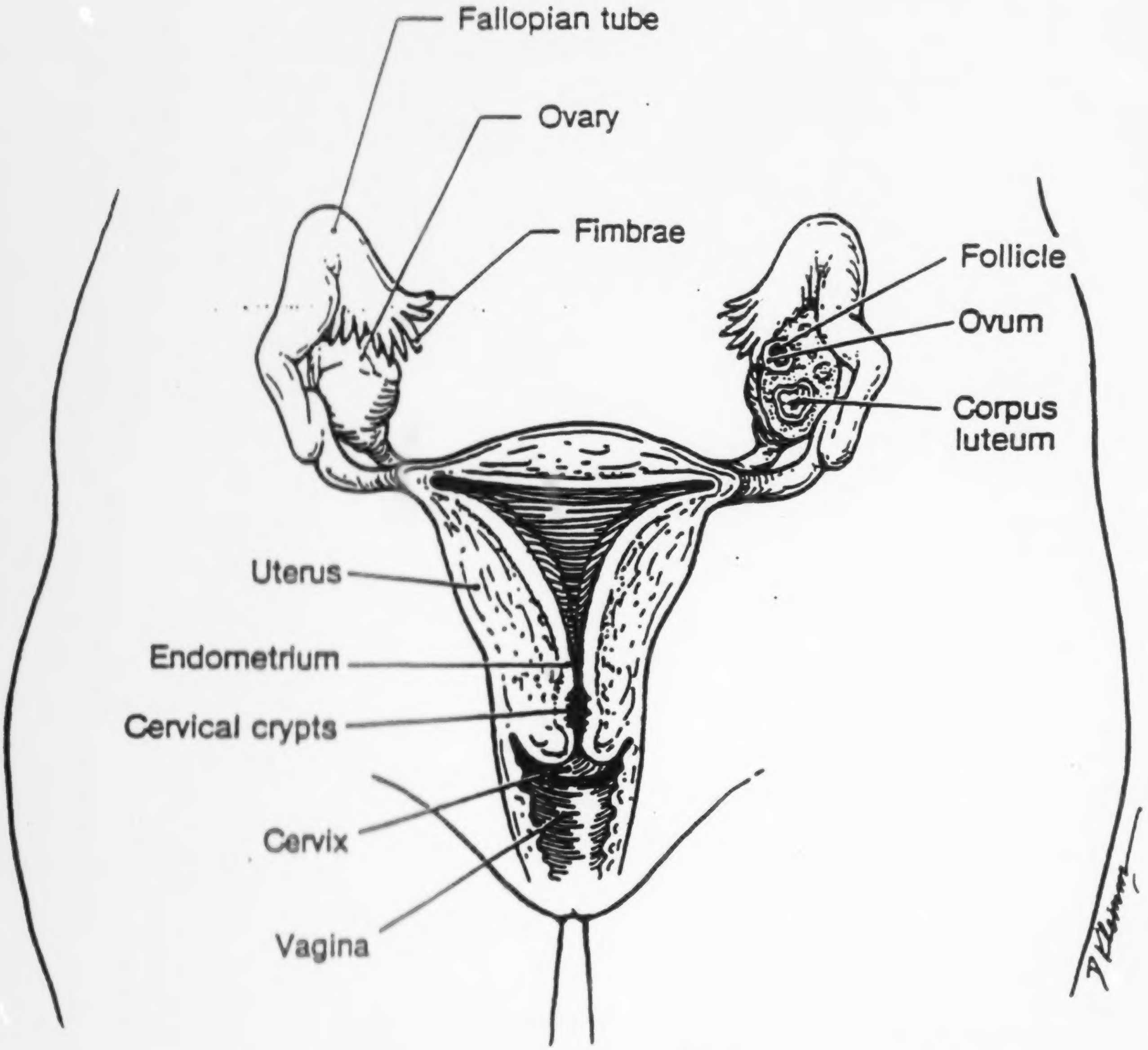
Figures taken from: Institute for International Studies in Natural Family Planning, Glossary of Natural Family Planning Terms, Georgetown University, May 1988.

FIGURE 1: Side View of Female Reproductive Organs


Fallopian tube
Ovary
Uterus
Cervix
Urinary bladder
Vagina
D Klemm

Adapted with permission from Resource Mothers, 1993.

FIGURE 2: Frontal View of Female Reproductive Organs (enlarged to show detail)


Fallopian tube
Ovary
Fimbrae
Follicle
Ovum
Corpus luteum
Uterus
Endometrium
Cervical crypts
Cervix
Vagina

Adapted with permission from Resource Mothers, 1993.

CASE STUDY SCENARIOS

CASE STUDY A

I am a 35 year old school patrol and live with a mechanic. I have four children and wish to stop having children. My partner is in agreement.

I would like to use the foaming tablet.

……

CASE STUDY B

I am a 26 year old mother of 1 year old healthy twins. My boyfriend wants more children, but I want to wait until they are in first-grade. My boyfriend recently went to the Red Cross to give blood, and he learned he was HIV-positive.

I would like to use Norplant.

……

CASE STUDY C

I am 21 years old and have a 3 year old child from my first husband. We're now divorced. I am pregnant with my boyfriend's child. He wants a large family but I want to finish my education and get a good job first. I am in good health, although I've put on lots of weight with this pregnancy.

I would like to use my old diaphragm after the baby is born. It's still in good condition, as I didn't use it regularly in the past.

……

CASE STUDY D

I am 29 years old and work at a bank. My boyfriend and I have two children and would like to wait for a few years before having another child.

I would Like to use the IUD.

……

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CASE STUDY E

I had a baby three months ago and am still nursing three or four times a day. I am a secretary and will soon return to work.

Since I am breast feeding, I do not yet need another family planning method.

……

CASE STUDY F

I am 35 years old and married to a cab driver. We have three children but I have been very sick at each birth. I have high blood pressure and was recently found to be diabetic.

My husband and I would like to use condoms.

……

CASE STUDY G

I am 30 years old and work at a restaurant. I live with a good man but he wants me to have more children. I would like to wait until my youngest child is three years old, but I do not want my partner to know that I am using a family planning method.

I would like to use Depo-Provera.

……

CASE STUDY H

I am 19 years old, work at K-Mart, and am married to a musician. I have no children. I would like to save some money and wait a year - maybe two years - before starting a family.

I would like to use Norplant.

……

CASE STUDY I

I am a 20 year old woman with one child. I dropped out of high school and never returned. I receive an AFDC check each month. I've never been married, but I have several boyfriends.

I'm not interested in using any family planning method. If I get pregnant, I'll have an abortion just like I did two years ago.

……

Adapted with permission from
Resource Mothers, 1993.

CASE STUDY J

I am 18 years old and just started college. My boyfriend has just received his diploma as an engineer. We would like to wait until I graduate from the university to have children.

We would like to use "natural" family planning, either calendar rhythm or the cervical mucus method.

……

CASE STUDY K

I am 22 years old and married to a government employee. We have one child. I am weaning the baby now and my partner and I have agreed to wait two years before our next child.

I would like to use the birth control pill (oral contraceptives).

……

CASE STUDY L

I am 36 years old and have always been a heavy smoker. My three children are all in school and doing well. Neither my partner nor I want any more children.

I would like to use the birth control pill (oral contraceptives).

……

Adapted From: Egyptian Ministry of Health and PATH, "Training of Trainers Workshop in Face-to-Face Communication", Cario, Egypt, mimeo, 1988.

UNIT 9
POST-UNIT TEST

- Condoms
- Norplant
- The Pill
- IUD (Intrauterine Device)
- Depo-Provera
- Vasectomy
- Diaphragm
- Sponge
- Tubal Ligation

1. How does it work?
2. Who uses the method?
3. How is it used?
4. Advantages
5. Disadvantages

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

POST-UNIT EVALUATION

UNIT COVERED: ______

DATE__________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? ______ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

Unit 10
INFANT FEEDING AND NUTRITION

This unit is designed to help participants understand the rationale for currently recommended feeding practices and to assist PSS in developing skills to support these practices. Although infant feeding is one of the most basic skills learned by new parents, it is a skill which is perfected with knowledge, time and experience. Feeding a baby entails much more than simply providing good nutrition -- it also involves learning to nurture and develop a special closeness with a new person.

It is important for the trainer to recognize that there are many deeply ingrained cultural customs, traditions, and beliefs regarding infant nutrition. As long as they do not interfere with the health and well being of mother and baby, these beliefs and traditions should be honored and respected.

On the other hand, our program may wish to encourage women to undertake infant feeding practices and methods which are not widespread in the target community, but which hold definite health advantages. Breastfeeding and delaying introduction of solid foods to 4-6 months are two examples. In this situation, the trainer is challenged first to convince PSS's of the advantages of particular practices and then to help them develop the skills necessary to gently encourage and support these practices in their clients. Because the PSS's credibility will be on the line when she tries to modify cultural traditions, it is important to provide her with ample opportunities to practice the skills she will need to carry out program objectives.

To help bridge the chasm between program expectations and community practices, trainers are encouraged to involve local WIC and Expanded Food and Nutrition Education Program (EFNEP) professionals in the development and presentation of this unit. Such professionals are knowledgeable about the nutritional needs of women and children in the community and as well, can contribute a wealth of information encouraging good nutrition and community nutrition resources.

Objectives

By the end of this unit, participants will be able to:

- Discuss the advantages of breast and formula feeding and identify feelings and values about feeding methods.
- Instruct clients on how to maintain breastfeeding.
- Discuss the effect of decreased nursing on milk supply and maternal comfort.
- Describe five ways a PSS can help promote breastfeeding success.
- Demonstrate how to prepare concentrated formula, powdered formula, and ready-to-feed formula.
- Describe how to prevent formula and expressed breastmilk from spoiling.
- Demonstrate to clients how to formula feed a baby.
- Discuss with clients when and how to begin solid foods.
- Identify four ways to prevent choking.

Time

7 hours

Adapted with permission from Resource Mothers, 1993.

Outline

A. Advantages of Breastfeeding
B. Promoting Breastfeeding Success
C. Formula Preparation and Storage
D. How to Formula Feed
E. Starting Solid Foods
F. Summary and Review

Materials

- Resource Mothers. (1993). Handbook. Sterling, VA: INMED.
- Infant Feeding Attitude Survey **(Handout #1)**
- Breastfeeding Basics Panel Discussion **(Training Aid #1)**
- Breastfeeding Role Play Scenarios **(Training Aid #2)**
- Introducing Solid Foods Role Play Scenarios **(Training Aid #3)**
- Role Play Feedback **(Overhead #1)**
- Handout listing local breastfeeding resources
- Baby doll
- Pillow
- Breastfeeding Video (Suggestion: "Breastfeeding is Best" or "Breastfeeding Your Baby: A Mother's Guide," #899-24, Medela, 1-800-Tell-You)
- Video on progression of infant feeding
- Handouts and/or posters depicting same culture breastfeeding mothers and babies
- Post-Unit Test
- Post-Unit Evaluation
- Blackboard and chalk or newsprint, markers and tape
- Video equipment: video camera, tripod, blank videotapes,television and VCR
- Other pediatric care resources such:
  Shelov, S.P. & Hanneman, R.E. (Eds.) (1991). The American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age Five. N.Y.: Bantam Books.
  Eisenberg, A., Murkoff, H., & Hathaway, S. (1989). What to Expect the First Year. N.Y.: Workman Publishing.

Advance Preparation:

- Review Chapters 8, Breastfeeding and 13, Infant Nutrition in the *Resource Mothers Handbook*.
- Assign Chapters 8 and 13 as background reading.
- Meet with local WIC professionals and solicit their support and/or participation.
- Order or borrow breastfeeding film or video. Arrange for a film projector or video equipment. Test all equipment ahead of time.
- Find out what breastfeeding support is available to clients of the program and prepare a handout.
- Purchase or obtain from formula company representative, concentrated formula, powdered formula, and ready-to-feed formula.
- Assemble all items needed to prepare infant formula including bottles, bottle brushes, nipples, water, pan, can opener, liquid soap, funnel, etc.
- Try out video equipment. Set up camera to videotape role plays.

Adapted with permission from Resource Mothers, 1993.

A. ADVANTAGES OF BREASTFEEDING (3/4 hour)

Rationale: Breastfeeding is such an important component of infant nutrition, yet many women do not understand how valuable breastfeeding is to their infants. It is important that Parenting Support Specialists appreciate the value of breastfeeding and learn techniques for encouraging and supporting new breastfeeding mothers.

Procedure: 1. Begin this session by giving participants an opportunity to examine their own values about breastfeeding. Ask participants to complete the Infant Feeding Survey (**Handout #1**). Reassure them that this is not a test of their knowledge and will not be collected. The purpose is for them to think about their beliefs about breastfeeding and formula feeding.

2. While everyone is answering the questions on the Infant Feeding Survey, place three large signs (these can be made with newsprint and tape) around the room: one with a "✓", one with an "x", and one with a "?". After participants have completed the survey, read some or all of the statements out loud, and ask participants to move to the sign that reflects their belief about the statement being read. Ask participants to refrain from judging others in the room.

3. Initiate a discussion, asking participants why some people feel the way they do about breast and formula feeding practices. Who are the people in a woman's life that are most likely to influence her breastfeeding practices, (i.e. mother, friends, sister, partner, etc.)?

Ask whether or not participants think it is possible for PSS' to influence how and what a mother chooses to feed her baby. How can PSS' influence infant feeding?

Possible answers:

- get to know the mother and develop a trusting relationship before discussing infant feeding.
- appeal to the client's desire to do the best she can for her baby.
- discuss advantages and disadvantages of breast and bottle feeding.
- listen closely to her concerns -- don't argue with her or contradict her.
- include others who might be influential in her decision in discussions about breastfeeding.
- accept that the final decision is hers.

4. Ask participants to name advantages of breastfeeding and formula feeding. You or a volunteer can record answers on separate sheets of newsprint titled "breastfeeding" and "formula feeding."

It may be difficult for participants who have not had much exposure to breastfeeding to think of many advantages. You should allow plenty of time for participants to come up with advantages on their own. Breastfeeding advantages **may include:**

Adapted with permission from Resource Mothers, 1993.

- Breast milk is perfectly designed for human infants. There is no substitute as well-suited to human babies.
- Breast milk protects babies from illness.
- Breast milk is digested more easily and completely than formula.
- Breast milk may help prevent diaper rash.
- Breastfed babies are less likely to get diarrhea than formula fed babies.
- Breastfed babies have healthier jaw and tooth development.
- Breastfed babies have fewer allergies.
- Breastfeeding promotes a close relationship between mother and baby.
- Breastfeeding may enhance a woman's sense of self worth.
- Breastfeeding helps the mother's uterus return to normal.
- Breastfeeding gives the new mother a chance to rest, relax and get to know her new baby.
- Breastmilk is clean and safe.
- Breastmilk is always at the right temperature.
- Breastmilk is always ready, day and night.
- Breastmilk is free.

Advantages of formula feeding may include:

- Most women have seen a baby being formula-fed and are therefore comfortable with the process.
- Anyone can feed the baby.
- Formula-fed babies don't need to be fed as frequently as breast-fed ones because formula takes longer to digest.
- Medications the mother uses won't be passed on to baby.

Given the advantages of breastfeeding and formula feeding, ask participants to think about how they would choose to feed a child of their own. Why?

B. PROMOTING BREASTFEEDING SUCCESS (3 hours)

Rationale: Some participants may have never observed a comfortably breastfeeding mother/baby pair in action. Just seeing successful breastfeeding women from their community may increase their comfort with breastfeeding and encourage PSS to support new mothers to breastfeed their infants.

Procedure: 1. **Activity.** Panel presentation. Rather than "lecturing" participants on how to start breastfeeding, organize a small panel of nursing mothers and/or experienced breastfeeding counselors (preferably from the community being served) who can provide helpful hints on breastfeeding basics and show participants how it's done. To this end you may also want to place posters around the room which

Adapted with permission from Resource Mothers, 1993.

depict breastfeeding mothers and babies representative of the culture the program serves.

The local WIC program director, professional lactation counselors, and the La Leche League will probably be willing to suggest panel members. The toll-free number for La Leche League International is 1-800-La Leche. You may call this number to locate the La Leche League nearest to the target community.

Arrange chairs in a semi-circle with all panel members sitting together. You or one of the experts will serve as the group facilitator. Open up the discussion by letting participants ask the panel members questions they have about nursing or about counseling nursing mothers. Panel members should be asked ahead of time to be prepared to answer the questions on **Training Aid #1**, "Breastfeeding Basics Panel Discussion." If necessary, the facilitator can use the questions on **Training Aid #1** to guide discussion. During the panel discussion, ask one of the breastfeeding panel members to demonstrate positioning and latching on techniques.

2. **Video**. There are many excellent films and videos which can be used to help teach breastfeeding basics. Check with the local WIC director to see if there are any available for loan in your community. Try to select a film which depicts mothers and babies of the same culture to be served by the PSS program. After the video is shown, ask participants for reactions and questions.

3. **Role play**. Ask participants to divide into groups of two, with one playing the role of client and the other playing the PSS. Present each with a scenario from **Training Aid #2,** "Breastfeeding Role Play Scenarios." You may want to design and substitute cases which are more culturally relevant to the neighborhoods served by participants.

Ask the pair to act out their roles in front of the large group. A baby doll can be provided to the "client". After the PSS has spent a few minutes counseling the client, invite other participants to help with ideas. Provide a lot of positive feedback for their good ideas.

4. **Reinforce** the importance of regular contact and support for breastfeeding mothers. Rather than waiting for clients to call with questions in the first few days after birth, the PSS may want to call or visit the client every couple of days to make sure breastfeeding is going well and to provide support and encouragement. The PSS might try to pair her client with a successfully breastfeeding mother in the community. Most successful breastfeeding women have support from other breastfeeding women.

Adapted with permission from Resource Mothers, 1993.

C. FORMULA PREPARATION AND STORAGE (1 hour)

Rationale: If women choose to formula feed it is essential they understand how to prepare formula correctly.

Procedure: 1. **Discussion.** Ask those participants who used formula to feed their babies how they decided which formula to use. Use this opportunity to discuss why cow's milk should not be given to babies for at least the first twelve months of life. Ask, "How does a mother decide what formula to use?" **Possible answers:**

- Health care provider suggestion.
- WIC program recommendation.
- Cost.
- Product name and recognition
- Attractiveness of packaging

"What should a mother do if a particular formula does not seem to agree with her baby?"

- Talk to health care provider.
- Talk with WIC provider.

2. **Demonstration.** Assemble all equipment necessary for formula preparation and ask for a volunteer to demonstrate how to prepare ready-to-feed formula. Ask another volunteer to demonstrate how to prepare formula from concentrate, and another to prepare powdered formula. (In lieu of selecting participant volunteers, you may want to invite a WIC professional to demonstrate and discuss formula preparation and feeding.) During the demonstration, discuss the advantages and disadvantages of each type of formula preparation. Cover the following teaching points:

- Handwashing before formula preparation.
- Checking the expiration date on formula cans.
- Cleaning/sterilizing all bottles, nipples, and other utensils used to prepare formula. Also sterilize pacifiers with nipples; have more than one pacifier that you give your baby regularly.
- Consequences of adding too much or too little water.
- When to use clean water and when to use sterile water.
- Importance of thoroughly mixing formula.
- How to sterilize bottles and milk.
- Safe storage of prepared formula and expressed breast milk.

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Adapted with permission from Resource Mothers, 1993.

D. HOW TO FORMULA FEED (3/4 hour)

Rationale: For women who choose formula feeding, it is important to know about its preparation.

Procedure: 1. **Discussion.** Ask participants what they think would be important to teach a new mother about formula feeding her baby. Write responses on newsprint.
Possible answers:

- Selecting nipples and bottles.
- Warming formula.
- Holding the baby and showing love during feedings.
- Amount and scheduling of feedings.
- Supplements.
- When to feed the baby water.
- Burping, hiccoughs, and spitting up.
- How to know when baby has had enough.
- Bottle propping and "baby bottle caries"
- Minimizing swallowed air.

2. Next, assign each participant a topic from the list the group just created (and additional topics you want to cover) and ask how she would discuss this topic with her client. Invite the rest of the group to provide encouragement and positive feedback.

E. STARTING SOLID FOODS (½ hour)

Rationale: Proper infant nutrition is essential for growth and development. Many new parents don't know when to start "solids" or what to feed an infant. Parenting Support Specialists can guide their choices.

Procedure: 1. **Discussion.** Ask participants how to know when baby is ready for solid foods. Signs of readiness usually occur at about four months of age. Write responses on newsprint. **Possible responses** may include:

- Baby sits up with support and holds head steady.
- Baby reaches for objects, grasps them and moves them to mouth.
- The baby stops pushing the tongue out when the lips are touched.
- Appetite increases.

2. Ask participants what solid foods are generally introduced first in their community. Discuss the pros and cons of these first foods. First foods should be ones that are easily swallowed and digested, so strain, grind, liquidize, get rid of seeds and rough skins of all foods. Sugar, fat and salt should be limited.

Ask about the disadvantages of adding solid foods to a baby's diet too soon. Solid foods are not needed before four to six months, they are incompletely digested and can be harmful to the baby's health. Ask how a Parenting Support Specialist can discourage a mother from adding solid foods to the baby's diet too soon.

3. Ask participants to suggest some ways to prevent infant choking. Have a volunteer record these ideas on newsprint. Refer participants to Chapter 13 of the *Resource Mothers Handbook*.

[**Note:** Invite someone certified in teaching how to handle infant emergencies such as choking during an in-service training.]

4. **Role play.** Ask volunteers to play "clients" and "PSS" in this activity or count off by "twos." Those volunteering to be the client will be asked to act out one of the roles from "Solid Foods Role Play Scenarios" (**Training Aid #3**). Give the "PSS" an opportunity to advise their "clients." Provide lots of positive feedback for appropriate techniques. Ask for other suggestions from the group. Again, you may wish to rework the case studies so that they are more culturally appropriate for the women in your community.

F. SUMMARY AND REVIEW (15 minutes)

Procedure: 1. Rephrase the objectives on the first page of this unit as questions. Ask a volunteer to answer each question.

2. Ask participants to write down two new things they learned about infant feeding.

3. Distribute post-unit evaluation forms.

4. Distribute post-unit test.

INFANT FEEDING ATTITUDE SURVEY

Please place a "✓" by the statements with which you agree, an "X" beside those with which you disagree, and a ?" by those statements for which you are not sure. This is not a test. Please do not put your name on this paper.

____ It is easier to bottle feed than to breastfeed.

____ Breast milk is better for a baby than formula.

____ Any woman is capable of breastfeeding her baby.

____ It is hard for a breastfeeding mother to tell if her baby is getting enough to eat.

____ Breastfeeding is more convenient than bottle feeding.

____ Breastfeeding ties you down.

____ The best way to calm a baby is to let him/her nurse.

____ Women should not breastfeed in public places.

____ Mothers who breastfeed have a closer bond with their babies than mothers who bottle feed.

____ Formula fed babies sleep better than breastfed babies.

____ Breastfed babies are healthier than bottle fed babies.

____ Breastfeeding is embarrassing.

____ I don't know many mothers who breastfeed their babies.

____ Women with small breasts don't have as much breastmilk as women with large breasts.

____ If I had another baby, I would plan to breastfeed.

Adapted with permission from Resource Mothers, 1993.

BREASTFEEDING BASICS PANEL DISCUSSION

When should a mother begin breastfeeding?

What if a woman does not have enough milk?

What is colostrum?

How do you get the baby to latch on?

What are some nursing positions?

How do you know if the baby is getting enough milk?

How long do you let the baby nurse?

Should you always let the baby nurse from both breasts?

How often should a mother feed her newborn?

How can a woman breastfeed discreetly when she is in public?

If a woman is returning to school or work, what can she do to be sure that she doesn't leak?

What if the baby doesn't seem interested in nursing?

If the baby is fussy and seems hungry after a nursing, should you give a bottle?

What if a mother needs to be away from her baby?

What can be done for sore nipples?

What can be done for engorgement?

What should a woman do if she wants to nurse her baby but her family disapproves?

Does a breastfeeding mother need to be on a special diet?

How do you express and store breastmilk?

Who can the Parenting Support Specialist call for help with breastfeeding questions?

BREASTFEEDING ROLE PLAY SCENARIOS

FUSSY BABY

Twenty-year-old LaToya has been home only two days with her new baby. She has been trying to breastfeed but the baby is very fussy. She tells you that her nipples hurt and she is miserable. Whenever she tries to nurse, the baby cries and pulls away. She is convinced that the baby hates her. Her mother announces loudly that the baby is crying because he isn't getting enough to eat. LaToya bursts into tears and tells you that she is quitting breastfeeding.

BREASTFEEDING DECISION

Alissa is the mother of a 3-day-old baby girl. You are visiting her for the first time. The father of the baby just walked out on her and she is angry and depressed. She tells you that she doesn't care a thing about the baby and she can't even think about facing all of those diapers and bottles.

SCHEDULING BABY

Yvonne calls to tell you that her one week old baby is crying all the time. You ask her how often she is breastfeeding the baby and she tells you she is trying to get her on a four hour schedule so she can get some rest.

NUTRITION FOR BREASTFEEDING

Brenda is nursing her one week old baby and she tells you that she is very thirsty but she isn't hungry at all. She boasts that she has lost most of the weight she gained during pregnancy. How do you respond?

BACK TO SCHOOL

Nineteen-year-old Cassandra has been successfully nursing her baby for five weeks but now it is time for her to return to work. She asks you for advice about weaning.

SUPPLEMENTAL BOTTLES

Yui has been nursing her baby for two weeks. While you are visiting her you notice a baby bottle partially filled with formula. When you ask her about it, she tells you that her mother likes to give the baby a bottle in the evening.

Adapted with permission from
Resource Mothers, 1993.

HIV INFECTION

Carla, a former substance abuser has just had a baby. She has recently learned that she is HIV positive. She also is positive for Hepatitis B. She tells you that she has decided to breastfeed her baby and asks you what she needs to do to get ready.

DISCARDING COLOSTRUM

You go to the hospital to visit Tiffany who is planning to breastfeed and she asks you how she can get rid of the thin fluid that is leaking from her breasts. She tells you she was told by her mother that it is bad for the baby.

Adapted with permission from
Resource Mothers, 1993.

INTRODUCING SOLID FOODS ROLE PLAY SCENARIOS

ADDING CEREAL TO THE BOTTLE

Your PSS asks how your baby has been eating and you tell her that Tameka is hungry all the time so you have been adding cereal to her formula.

……

EARLY SOLID FOODS

When your PSS visits you, you proudly show her how 2 week old Jaime is taking mashed potatoes.

……

BOTTLE PROPPING

Before you sit down to talk to your PSS, you first place three month old Nita in her crib and prop her bottle for her.

……

ADDED SALT

Just as you and your four month old baby Jared are sitting down to breakfast, your PSS comes to visit. You salt your eggs and then offer the baby a bite.

……

SPOILED FOOD

You are feeding your baby directly from a large baby food jar of cooked carrots. When your PSS comes, you screw the lid on the carrots and set them aside.

……

CHOKING HAZARDS

You are just beginning to feed your eight month old baby lunch when your PSS comes to visit. You tell her how much your baby enjoys eating hot dogs.

……

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UNIT 10
POST-UNIT TEST

1. Describe 3 advantages and 3 disadvantages to breastfeeding and formula feeding.

Breastfeeding	**Formula feeding**
Advantages:	Advantages:
1.	1.
2.	2.
3.	3.
Disadvantages:	Disadvantages:
1.	1.
2.	2.
3.	3.

2. Describe 3 ways to encourage breastfeeding success.

   1.

   2.

   3.

3. Describe how to prepare concentrated formula and powdered formula.

Adapted with permission from Resource Mothers, 1993.

4. What would you tell a client about how to formula feed her baby.

____

____

5. Identify 2 ways to prevent choking.

1. ____

____

2. ____

____

Adapted with permission from
Resource Mothers, 1993.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

Adapted with permission from Resource Mothers, 1993.

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

Adapted with permission from Resource Mothers, 1993.

POST-UNIT EVALUATION

UNIT COVERED: _____

DATE_______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

Adapted with permission from
Resource Mothers, 1993.

____

____

4. Was the information in this unit presented clearly? _____ If not, please explain.

____

____

____

____

Adapted with permission from Resource Mothers, 1993.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

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Unit 11
HEALTH CARE IN THE FIRST YEAR

This session is designed to reinforce and practice the baby care skills that participants already have. In addition, participants will learn how to teach these skills to their clients. Participants will recall their first experiences with their own (or friends' or family members') newborn babies, practice and review comforting techniques, and model and role play baby care skills. Preventive care and ways to ensure a safe environment for baby will be reviewed and reinforced.

Objectives

By the end of this unit, participants will be able to:

- Describe physical characteristics of the newborn.
- Describe and demonstrate three comfort techniques.
- Model child care skills that new parents need to know.
- Using a chart, describe to clients which immunizations a baby needs, and at what age; explore parent's concerns regarding immunization safety.
- Describe at least five safety hazards in the home and for each one, ways to "baby proof" a child's environment.
- Describe how a parent can tell if a child is sick.
- Demonstrate how to take a baby's temperature.

Time

8.5 hours

Outline

A. Introduction/Parenting
B. Physical Characteristics of the Newborn
C. How To Comfort a Crying Baby
D. Modeling Infant Care Skills
E. Preventing Illnesses
F. Taking Care of a Sick Child
G. Safety
H. Practice Session: Role Plays and Case Studies
I. Summary and Review

Materials

- Resource Mothers. (1993). Handbook. Sterling, VA: INMED.
- Infant States and Parents Responses **(Handout #1)**
- What Your New Baby Will Do **(Handout #2)**
- Kitchen Hazards **(Handout #3)**
- Home Safety Tips **(Handout #4)**
- Suggestions for Safety **(Handout #5)**
- Infant States **(Training Aid #1)**
- Calming a Baby **(Training Aid #2)**

Adapted with permission from
Resource Mothers, 1993.

- Case Study: Helping Mother Comfort her Baby **(Training Aid #3)**
- To Hold or Not to Hold **(Training Aid #4)**
- Baby Care Needs **(Training Aid #5)**
- Taking Care of a Baby **(Training Aid #6)**
- Safety Role Plays **(Training Aid #7)**
- Case Studies **(Training Aid #8)**
- Role Play Feedback **(Overhead #1)**
- Post-Unit Test
- Post-Unit Evaluation
- Baby doll(s), as life-like in size as possible
- Baby bathtub or sink
- Oral and rectal thermometer(s)
- Immunization schedules
- Video Equipment: video camera, tripod, television, VCR.
- Video: "Comforting Your Crying Baby" or other suitable video showing calming techniques. This one is available from: Parent Infant Resource Center, Department of Psychology, Georgia State University, Atlanta, GA 30303-3083, Tel: (404) 651-2928.
- Video: "What Lilly Learned -- Immunizations" Crommie & Crommie, ALTSUL Group Corporation, Evanston, IL 60201.
- Video: "Preventing Childhood Injury" Mead Johnson Nutritional Infant Care Series for New Parents, Bristol Meyers U.S. Pharmaceutical and Nutritional Group, Evansville, IN 47721.
- Easel, newsprint, markers, tape and/or blackboard and chalk
- Colored chalk for "Immunization Hopscotch"

Advance Preparation:

- Make sufficient copies of handouts.
- Read the *Resource Mothers Handbook*, Chapter 1[illegible], "Taking Care of a New Baby," and Chapter 15, "Safety."
- Assign these chapters to participants as background reading.
- Review above videotapes.
- Make transparencies of **Training Aids #2 and #5** and, if appropriate, of **Handout #3.**
- Make a tape of a crying baby (optional) for Section C.
- Find pictures of a healthy newborn and a low birthweight newborn. The March of Dimes is a good source.
- Copy and cut up **Training Aids #8 and #9** to give out as role plays.
- Bring a copy of Eisenberg, A., Murkoff, H. & Hathaway, S. (1989). What to Expect in the First Year. N.Y.: Workman Publishing. (or other popular book on child care).
- Make copies of **Handout #4**, Home Safety Tips, for each trainee. If you plan to make hundreds of copies to use with your clients, the Consumer Products Safety Commission will be printing copies of Home Safety Tips later this year (1993). For more information, call Elaine Tyrell at the Consumer Products Safety Commission, (301) 504-0580. Or, you can obtain the original artwork from the National Healthy Mothers/Healthy Babies Coalition. For more information, call: Tel: (202) 638-5577.
- Another resource for parenting skills development that you may wish to review is: Honig, A. (1982). Playtime Learning Games for Young Children. Syracuse, N.Y.: Syracuse University Press.

Adapted with permission from Resource Mothers, 1993.

To obtain a copy, write: Syracuse University Press, 1600 Jamesville Road, Syracuse, NY 13210.

Try out video equipment. Set up camera to videotape role plays.

A. INTRODUCTION/PARENTING (3/4 hour)

Rationale: Although Parenting Support Specialists already have experience taking care of new infants, this unit provides an opportunity to update the information and to practice ways of best transferring accurate information and skills to their clients.

Procedure: 1. **Mini-lecture and group discussion.** Begin this unit by pointing out that trainees will be working together on ways to transfer information and skills about the care of an infant, and thus help new mothers reduce their anxiety levels and enjoy their new roles as mothers. Let participants know that they have more cumulative experience in taking care of infants than you do, and that this session will really be a review of a variety of materials with which they may be familiar.

However, child care is not a static field. The pediatric community changes the advice they give new mothers as new theories, studies, and test findings warrant. Ideas and practices about the use of pacifiers, spoiling a baby, how infants perceive the world, ways of holding an infant, and even the types and number of immunizations has changed over the past fifteen to twenty years. This Unit will help trainees integrate new knowledge with previous experience.

2. A human infant is completely dependent on his/her caregivers. That's usually the mother, although many fathers also take an active and involved role. Do participants think this last statement is true and, if so, is it good? Why or why not? Before moving to the next topic, mention that when participants make postpartum home visits, they should be alert to the fact that some fathers may also want some skills training (but may feel it's "unmanly" to come out and say so).

3. "**Parenting**" may not even have been a word when some of the trainees were first parents, but it's come to be associated with all the things to do -- and the skills needed -- to be good parents. Ask participants to think of all the things one must do to take care of (or "parent") an infant. Ask someone to write this list on the board. Overwhelming, isn't it? Babies need so much!

Ask the group to look again at the list they just prepared, and decide if an item meets a physical need or an emotional need -- or can it be both? For example, changing a baby's diaper when she wets meets a physical need to be kept clean and not let her body get sore or chapped. But, over the first months of her life, being changed when she wets or dirties herself will help a baby build a sense of trust as she begins to sense that she can count on someone "being there" for her. Thus the act of changing an infant regularly and not letting her stay uncomfortable and wet can meet an emotional need as well.

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Is it fair to say that all babies need TLC (tender, loving care) and that anything a parent does to meet her baby's physical needs, provided she does it in a caring fashion, will show the infant that she is loved, and will thus also meet her emotional needs? Discuss.

4. Mention the fact that people are not born with good parenting skills. Rather, parenting skills are learned. But these skills don't come naturally, at least not to most people. Ask trainees how new moms and dads learn these skills. How did each of them (who are mothers) learn them? **Possible responses:**

- Trial and error
- From watching my mother, friend or other family member
- From watching a film or video
- From helping a neighbor (babysitting, etc.)

Being a good parent is hard work, and very time consuming. And yet most people receive no special training for what is probably the hardest (and also, potentially, the most rewarding) job they'll ever have!

5. **Discussion.** Oftentimes new mothers are not prepared, either emotionally or intellectually, to be a parent. What kind of a challenge does this present to a PSS, working with such a client in her home? Ask participants what they would say or do when faced with a new mom who just "doesn't want to be bothered."

6. Mention that, at the end of this unit, trainees will have time to role play a variety of situations where they will need to make use of all their "old" parenting skills plus some new ones they may acquire during training.

B. PHYSICAL CHARACTERISTICS OF THE NEWBORN (3/4 hour)

Rationale: Newborns may look "funny" to a new parent. PSS' can reassure their clients that characteristics of a newborn are normal and will probably disappear in a short time.

Procedure: 1. **Discussion and activity.** Ask trainees to think back to when they were 9 months pregnant and expecting their baby any day. How did they picture their baby? What did they think their baby would look like? Then ask trainees to take out a piece of paper and write down four things they remembered thinking **before** their baby was born.

Now show trainees the picture of the two newborn babies--one healthy and one premature--the pictures of newborn babies that you collected. Ask them to write down four words that describe the picture. After a couple of minutes, ask a volunteer to share her description of the baby she "dreamed of." Then ask a volunteer to read her description of the baby in the picture.

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Ask trainees what some of the differences in their descriptions were. How do new mothers often feel when they first see their newborns? **Possible responses**:

- Excited/relieved
- Frightened
- Disappointed
- Nervous or scared they won't be able to take care of the baby
- Overwhelmed

2. **Discussion**. Ask the trainees if they remember what some of the physical characteristics of a newborn are that make them "funny looking." **Possible responses**:

- Skin looks wrinkled; may have blue patches, birthmarks, or white pimples.
- Eyes and face are puffy or swollen
- Eyes look crossed
- Head is pointed
- Body is covered with fine hair
- Breasts and genitals are swollen and large

3. **Discussion**. Emphasize that it's normal for newborns to spend much of the time sleeping. Ask trainees what babies are usually doing when they are not sleeping. **Possible responses**:

- Crying
- Hungry/eating
- Looking around
- Moving their arms/legs

Show trainees the overhead transparency made from **Training Aid #1**, Infant States. "Infant states" are the different levels of waking and sleeping that a baby goes through during each day. The different states are:

✓ Quiet sleep
✓ Active sleep
✓ Drowsy
✓ Quiet Alert
✓ Active Alert
✓ Fussy
✓ Crying

Ask trainees if they think it is important for parents to recognize and be aware of the different states of newborns. Why or why not? Why might it be important to recognize the quiet alert state? What types of signals do newborns give their parents? **Possible responses:**

- If a parent learns to recognize her baby's states, then she will get to know her baby better.

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- If a parent can recognize the quiet alert stage, the parent will know when the best time is for feeding or playing.
- Different signals include looking away after too much stimulation, fussing when hungry or tired, or kicking and waving arms when excited.

3. **Activity.** Pass out **Handout #1**, Infant States and Parent Responses. Ask trainees to look at each of the infant states in the left hand column. Then in the right hand column, note what they can recommend that a mother do at the corresponding time. You can do this exercise with trainees, or just go over the first one and let them fill in the rest on their own. For example, during the baby's quiet sleep what can a mother do? Answer: rest or nap. Allow about five minutes to complete the form, then share responses.

Before moving on, recommend that trainees save this handout in their *Handbook* so they can share it with new mothers.

4. **Activity.** Distribute **Handout #2**, What Your New Baby Will Do. Have trainees break into groups of two. Ask them to take turns role playing a home visit and finding a new mother all upset because she does not know what to expect from her newborn. As her PSS, each trainee can use this Handout to review with the new mother what to expect from her baby. After everyone has had a chance to participate, ask the trainees if there was anything missing from the handout that they remembered about their own infants' behavior, or if there was anything they disagreed with. Why? Discuss. Add any suggestions to the handout and ask trainees to save it in their *Handbook*.

C. HOW TO COMFORT A CRYING BABY (3/4 hour)

Rationale: Crying is normal. Babies cry because it is their only way of communicating that they need something or that something is wrong. PSS' can help new mothers to identify infant needs and comfort their infants.

Procedure: 1. **Discussion**. Ask trainees why they think babies cry. Brainstorm as many reasons as possible, **for example**:

- To tell us what they need
- Because they are tired, hungry, cold, hot, sick, bored, or want to be held
- They sense that their mother stressed, sad or angry

Emphasize that crying is normal. Babies cry because it is their only way of communicating that they need something or that something is wrong.

2. Ask the trainees if they remember what they did to comfort their crying babies. What seemed to work? What didn't work? **Possible responses:**

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- Baby calmed him/herself down on his/her own by sucking on fingers, fist or pacifier
- Walking the baby
- Rocking
- Singing

If someone mentions pacifiers, take the opportunity to ask the group what they think about the use of pacifiers. You may want to mention that mothers who choose to breastfeed may want to avoid giving their babies pacifiers in the first few weeks as pacifiers may cause the baby to have "nipple confusion." If you do use a pacifier, use more than one regularly so you will have the opportunity to sterilize. Do not put your baby's pacifier in your mouth to clean it.

3. Project a transparency of **Training Aid #2**, Calming a Baby, on the wall. Does it list any other responses that trainees might have overlooked? Discuss. Suggest that trainees write any new suggestions in their *Resource Mothers Handbook*.

4. Not every comforting technique will work with every baby. And the same thing that comforted a baby one day might not do the trick the next day. Parents have to find out what works best for themselves and their babies.

5. **Case Study**. Read the case study found in **Training Aid #3**, Helping a Mother Comfort her Baby. Then ask trainees to discuss the questions presented in the case study.

6. Ask trainees how they felt when their baby cried for long periods of time. They may have felt frustrated or even angry. What did they do to give themselves a break? What ideas can they give clients who are feeling frustrated? You may want to tape a crying baby ahead of time and play the tape for a few minutes to stimulate discussion! **Possible responses:**

- Get help from a friend or family member.
- Go out for a walk with baby, change of scenery.
- Put baby down in a safe place, go in another room and set time for ten minutes. Let baby cry and then return and try more calming techniques.

Trainees can add any new suggestions that they come up with to the list in their *Handbook*.

Trainees should also know that long periods of crying may mean a baby is sick or in pain. If a mother is unsure, she should call her health care provider. If a mother says she feels she might harm her baby because the baby won't stop crying then she should get help immediately. Ask trainees if they know what the telephone numbers are in their community for someone to call for help in this

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emergency situation. If not, where will they find this information? They should refer to their notes in Chapter 5 of the *Resource Mothers Handbook.* Trainees should practice helping clients find the phone numbers, write the phone numbers down and post the numbers by the client's telephone.

7. **Discussion on Spoiling a Baby.** Begin this discussion by first presenting the following scenario, or a similar one of your own:

"I'm a PSS and I just came back from my first visit with Dana since her baby Shawn was born three w[illegible] ago. When I got to her apartment she was in tears. Her grandmother had just left. Dana's grandmother had yelled at her and said, 'Every time I come over here you are holding that baby of yours. Shawn's going to be real spoiled if you don't put him down and just let him cry.' Dana was devastated since she loves and respects her grandma a lot. She feels like she must be a terrible mother. She doesn't think she does anything right."

Ask trainees what they think about the grandmother's point of view. What do they think about Dana's point of view?

Show transparency, **Training Aid #4,** To Hold or Not to Hold? Ask trainees for their opinions. Do they think a baby can be spoiled? Why or why not?

8. **Video.** If time allows, show a video on comforting techniques. One 14 minute video on the topic is "Comforting your Crying Baby." (See overview of Unit for details.)

D. MODELING INFANT CARE SKILLS (1-1/2 hours)

Rationale: Begin this section on modeling behavior with a ten minute exercise (an adaptation of "Simon Says") aimed at reinforcing the need of a PSS to be a good role model. It's also a good opportunity for everyone to stand up and stretch.

Procedure: 1. **Exercise.** Give participants the following instructions:

- Ask them to stand in a circle.

- They should follow what you **say**, not what you **do.** Whoever does not will have to lead the game.

SAY	DO
a. Point to your elbow.	a. Point to your elbow.
b. Point to your chin.	b. Point to your chin.
c. Point to your toes.	c. Point to your chest.

- Anyone who has pointed to her chest is the new leader. This person now gives new commands, making sure she sometimes says one thing but does another.

- After about five minutes, stop and process this exercise by asking trainees what we can learn from it. Someone will probably say that, despite your instructions, people will do what you do, even if it conflicts with what you say.

- End by explaining that as they have seen from this exercise, new mothers will tend to follow their example, not what they may have said. Thus it is important for a PSS to be a good role model, and "practice what you preach." This exercise leads into the session on modeling.

2. **Exercise.** Which do trainees think is easier, to demonstrate how to do something, or to explain something verbally without the benefit of being able to model the procedure or to show a picture of how it is done? Why?

To demonstrate this, ask for a volunteer to instruct the group in some common procedure like tying a shoelace, without showing the group what to do. Use words only, no hand motions or demonstrations. If this skill were new would it be possible to copy her behavior from her verbal explanation? Why or why not?

Now ask this same volunteer to demonstrate the procedure (in this case, tying a shoelace) without any commentary. Actions only. Will someone who has never tied a shoe be able to model this behavior? Why or why not?

3. Ask if anyone has any suggestions for the volunteer to make it easier for the learner to follow her instructions. **Possible responses** might include:
- Do both of the above: model and explain
- Ask the learner to demonstrate what she has seen/been told

Remind the group that a person's likelihood of remembering new information about how to do something is almost three times greater if they actually do it, than it is if they just hear about it; and almost twice as great as it would be if they heard and saw what to do, but didn't actually do it themselves.

Ask what this tells trainees about what they should do with their clients during postpartum home visits. **Responses** include:
- Model how to do certain things for the baby.
- Talk to the client at the same time and let her know what you're doing and why.
- If possible, leave her with some pictures material that she can refer back to if she forgets something.

4. Project a transparency of **Training Aid #5,** a drawing of a newborn. All those marked body parts are going to need attention from the mother. Should the transparency have labeled anything else that needs care? [**Note:** You can add new labels if the group has additional suggestions.] Discuss the sorts of skills you can model and discuss when training your clients how to care for their babies. What are some of the routines that you can show and explain to a new mother, if you can tell she is nervous and/or doesn't know what to do? **Possible responses** will include:

- How to bathe an infant
- How to care for the umbilical cord (also the penis, if a male baby has been circumcised)
- How to change a diaper (cloth vs. disposable)
- How to dress an infant
- How to swaddle an infant (only applicable in first month or so)
- How to hold an infant
- How to care for a baby's skin
- How to soothe and comfort a fussy baby (discussed earlier)
- How to take a baby's temperature

Trainees should make sure they can model proper handwashing, and explain to mothers that washing their hands well with soap each time they change a diaper (or go to the bathroom themselves) is the best way to keep germs away from their babies.

[**Note:** If PSS are working with clients who are at risk of HIV infection or Hepatitis B, you may wish to discuss universal precautions at this time. See Section G on Safety.]

5. **Activity**. Ask participants to pair off in teams of two. Assign two or more of these baby needs to each team (the number will depend on how many trainees are in the course), and have the team members jot down all the steps they will need to demonstrate and the advice they will need to give, at the same time, to a new mother.

When they have finished, ask team members to report on, and demonstrate to the class how she would instruct a client. For example, how she would demonstrate the steps involved in changing a baby, and what things she should point out to the mother (like wiping a female from front to back or how to carefully pull back the foreskin to clean an uncircumcised male). Have each person use a doll to model the routine that the mother should follow. Remind her to be sure to talk to their "baby" at times, just as they want the mother to do.

[**Note: Training Aid #6,** Taking Care of a Baby, reviews some of the points that should be covered -- and, if possible, demonstrated -- for each of the procedures.

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Use it, if needed, to augment anything important that's left out of a presentation. Some of these topics are also covered thoroughly in the *Resource Mothers Handbook*. Information that is included in the *Handbook* is **not repeated in Training Aid #6**.]

When she is finished, ask other participants if she forgot anything or if any part of her demonstration/advice was inaccurate or confusing. Discuss.

Then go on to another team member for another presentation of modeling/explaining. Continue until all the baby needs have been covered. This is a good session to videotape, and play back later on, if you have the equipment.

6. Before going on to the next section, ask if anyone has additional comments or suggestions of "tips" that may help the new mother. Be sure to point out that every client, just like every baby, is unique, and that they will not all need the same amount of help with each skill. By observing mother-baby interactions, the PSS probably will be able to tell just how much "hands-on" help each client needs. Also remind participants that it's not enough to demonstrate a skill; they have to then observe the client as they demonstrate all that they heard and saw.

E. PREVENTING ILLNESSES (1 hour)

Rationale: Since a baby's wellness is important to her growth and development, it is important to be aware of how to try to prevent illness whenever possible.

Procedure: 1. **Discussion**. Introduce this topic by asking trainees if they have heard the words "preventive medicine" and "curative medicine." Any ideas as to what these terms mean? Do they know any word that sounds like "preventive?" Someone may say "prevent" or "prevention." Ask what it means "to prevent" something. Together the group will probably determine that "preventive medicine" means doing things to prevent illness.

Next have a similar discussion of the word "curative." Someone will probably respond with "cure" or "curing." "Curative medicine" involves some sort of treatment so that a sick person is "cured" or becomes well.

Ask the group which is better: preventive or curative medicine? Why? Discuss. Be sure to point out that all babies are bound to get sick at some time and parents should not feel guilty or blame themselves if their child becomes ill. These things happen. However, there are actions parents can take which will help **prevent** their child(ren) from becoming ill. Discuss. **Possible responses** include:

- Take baby for routine physical care (well-baby check-ups)
- Make sure babies get immunized

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- Have people wash their hands before touching or holding infants/young babies. (This could be controversial, but it is worth discussing: Is it realistic? Why or why not? What does washing with soap and water do? etc.)
- Keep babies away from others (children and adults) who are sick
- Dress the baby for the weather
- Keep the baby clean, change dirty diapers as soon as needed

Ask trainees to discuss **why** children are immunized. A **possible response** includes:

- prevention of life threatening diseases

Ask if it is important that a child gets all the immunizations. **Possible responses** include:

- Yes, for many of the diseases, a child is not fully protected until he or she gets all the shots. That is why it is very important that mothers make sure their children receive every immunization available to them.
- Also a non-immunized child could catch the disease and spread it to the baby and other children in the community.

Ask now immunizations are given. **Possible answers:**

- By injection (or shots)
- By mouth (only polio, so far)

Show video: "What Lilly Learned -- Immunizations."

2. **Activity.** Assign each person one of the nine diseases for which children are immunized in the United States: Tetanus, Diphtheria, Whooping Cough (Pertussis), Polio, Measles, Mumps, Rubella (German Measles), Hepatitis B, and Hemophilus (Meningitis). (If there are more than nine participants, give several people the same disease assignment; if there are less than nine, give some people two. Make sure each disease is covered.)

Say to the group that immunizations are kind of like hopscotch. You need to jump on all of the squares in order to get the prize. [Explain what are the rules of hopscotch if trainees are not familiar with this game.] Ask everyone to come outside or somewhere where you can draw on the floor. Suggest that they bring their *Resource Mothers Handbooks* and turn to the pages on immunization.

With them, draw a giant hopscotch board on the ground like the one shown below. Make sure that the squares are big enough to jump in. You may want to use a different color chalk for the boxes. Write the months along the side, and write the immunizations that should be given in those months in the large squares.

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- ✓ Have each person take a small coin or pebble to use as her marker. Ask the group to divide into 2 teams.

- ✓ The first player throws the marker and aims for the disease that was assigned to her. If her marker lands within the proper square, she tells the others what this immunization will protect against and at what age(s) children should receive their immunizations. Then her team gets a point, and the first player on the other team throws and "explains" her disease and what could happen in the absence of the complete immunization series for that disease. (If a marker lands on the wrong square, or on a line, if the player cannot explain her disease or her immunization schedule fully, then that player's team does not get a point. In cases of disputed information, the trainer serves as referee.)

[**Note:** You can make this game a dart board or a dice game and follow a similar procedure.]

Birth				Hepatitis B
1-2 Months				Hepatitis B
2 Months	DPT	Polio		Hib
4 Months	DPT	Polio		Hib
6 Months	DPT			
6-18 Months			MMR	Hepatitis B
15 Months				Hepatitis B
15-18 Months	DPT	Polio		
4-6 Years	DPT	Polio		
11-12 Years				MMR
14-16 Years				Diphtheria-Tetanus

Continue taking turns until all players have had at least one turn and all diseases have been discussed. The team with the most points at the end is declared the winner.

Back in the training room, ask if anyone in the group has had a child who has experienced a negative reaction to an immunization.

Discuss possible side effects, such as crankiness, fatigue or a swelling at the area of injection. Tell the PSS' to suggest mothers are usually advised by the health care provider to give the child acetaminophen, (not aspirin), if she feels some relief would do the child good. Discuss possible concerns about immunization safety.

F. TAKING CARE OF A SICK CHILD (1 hour)

Rationale: New mothers will need help to recognize when their babies are sick, and learn how to care for them. A PSS can help with practical ways to respond to a sick baby's needs. A PSS can also help mothers learn when to call the health clinic and when their baby needs emergency care.

Procedure: 1. **Discussion and activity.** Ask participants if they remember any of the common problems or illnesses they dealt with when their children were small.

Possible responses:

- Diaper rash
- Teething
- Fever
- Thrush
- Colds
- Ear infections
- Diarrhea

Have a volunteer write each of the problems/illnesses on newsprint or the blackboard. Leave space next to each one for writing some common home treatments applicable to these problems. Start with one illness and ask the group how they would treat it. Ask the volunteer (or a new one) to fill in treatments next to each problem/illness as the group discusses them. You may want to have one of the popular child care books available to refer to in case the group has questions. (One example is A. Eisenberg et al, *What to Expect the First Year*, Workman Publishing, New York, 1989.)

Discuss when a problem becomes so serious that the health care provider should be called, for example, a diaper rash that doesn't go away, or the first signs of an ear infection. Discuss any treatments that the group disagrees with, for example, the best treatment for diaper rash or whether to give babies medicine to numb their gums during teething. Let trainees know that sometimes there will not be one right answer. Different strategies or approaches are okay as long as they are not harmful to the baby. Remind the group that aspirin is not to be given to children because of the link to Reye's Syndrome.

3. Ask participants to name some of the serious signs that a baby is very sick.

Possible responses:

- High fever
- Not eating or drinking fluids
- Weak and lifeless
- Persistent vomiting or diarrhea

The *Resource Mothers Handbook* has guidelines for when a mother should call her health care provider. Review these guidelines and be sure each trainee understands each point. If time allows, ask the group if anyone wants to share

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any personal experience of having a very sick baby and having to know what to do for the child. Also review your program's policy about PSSs giving medical advice.

4. **Discussion.** Usually a mother can tell if her baby is sick when the baby is especially cranky or not him/herself. Ask participants if they think parents should know how to take their baby's temperature? If so, why is it important?
Possible responses:

- By monitoring the baby's temperature she will know if the baby's fever is getting dangerously high.
- She will know when the fever has gone down.
- Her health care provider or clinic may ask her how long the baby has had a fever and how high the fever has been.

There are two ways to take a baby's temperature, under the armpit (the axillary method), and in the rectum (the rectal method). The trainer should know which method the health clinics where most mothers take their babies recommend and also review both methods with the trainees.

Pass around a rectal thermometer and an oral thermometer. Ask the group if they notice the difference between the two. The oral thermometer has a longer bulb and can be used either in the mouth (but not in babies or small children who might bite down on it) or under the armpit. The rectal thermometer can be used in the rectum or under the armpit.

5. **Activity.** Ask the group for a volunteer to demonstrate and explain step by step the process of taking an axillary temperature of your baby doll. Have the group assist the volunteer if she asks for help at any point during her demonstration. Then have a second volunteer to demonstrate taking the rectal temperature of your plastic baby. (She may have to "pretend" to insert the thermometer.) Ask the volunteer to include what should be done to the thermometer before and after the thermometer is used. Again, ask the group to help her out or to bring up anything she forgot.

After the demonstrations are over, have the group check in the *Resource Mothers Handbook* for any steps they forgot. Mention these steps.

Be sure everyone gets a chance to practice reading a real thermometer in case there are any questions about how to read it.

G. SAFETY (1-1/2 hours)

Rationale: In the United States, accidents are the number one cause of death in children under five. Most injuries are caused by car accidents, but improperly used or unsafe highchairs, toys, cribs have also sent many children to the hospital. Accidents are more likely to take place when

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a family is distracted because they are under stress. PSS can help clients "baby proof" their homes, thus helping to reduce the number of home-based accidents.

Procedure: 1. **Exercise.** Distribute **Handout #3**, Kitchen Hazards, or if it's easier, make a transparency and project it on a screen or the wall. Ask the group what hazards they see in this illustration and how to avoid them. Put an "x" through each one after someone mentions it. **Possible answers** includes:

- stool next to burners/remove stool
- easy access to open window/put in window guard
- open sockets/use socket plugs
- roach poison in their child's reach/put higher
- knife easy to reach/put higher
- detergents easy to reach/use cupboard latches or move up
- cord dangling/wrap up so child can't pull toaster down
- pot handle easy to reach/move so handle points towards wall
- lighter and cigarettes easy to reach/put higher and have fire extinguisher available
- tub of water on floor/empty when child not being supervised

2. Show video: "Preventing Childhood Injury."

3. Post sheets of paper with the following headings around the room:

Bathroom Safety
Other Home Safety Tips
Ways to Prevent Choking
Pacifiers
Poison Prevention
Preventing Lead Poisoning
Cribs
Playpens
Changing Tables
Highchairs
Infant Seats
Walkers
Toy Boxes and Toy Chests
Controlling Safety Outside the Home
Baby Carriers
Strollers and Baby Carriages
Water Safety
Sun Safety
Safety Around Animals

4. Give each participant a felt pen and ask the group to go around to the different sheets of paper and write a few suggestions on child safety that are relevant to the particular heading. For example, under the heading "changing tables" someone might write "never leave baby unattended on this." Or, under "infant seats" another person might put "If the baby's in this, put it on the floor, not on a table where he/she might fall." Ask each participant to start on a different piece of paper, and then rotate around the room, until each participant has had a chance to add to the lists made by her predecessors.

5. When they are finished, have one person read each sheet. Then discuss and fill in additional points. Use Chapter 15 of the *Resource Mothers Handbook* for ideas. Also distribute **Handout #4**, Home Safety Tips, which participants may

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want to consult for this exercise, and then keep to share with clients. [**Note:** Program managers can obtain copies of the original artwork from the National Office of the Healthy Mothers/Healthy Babies Coalition; Tele: (202) 638-5577, if they wish to use it to make clean copies to distribute to program clients.]

6. **Role plays**. Cut up the roles from **Training Aid #7**, Safety Role Plays, and put them in a container. Have everyone take a slip of paper from the container, including yourself. Begin by describing (or demonstrating) what your slip of paper says this client is doing incorrectly. Ask for a volunteer to "play" the PSS and say what advice she should give you, the client. When you and the volunteer have finished, ask everyone to provide constructive criticism.

7. Next the person who just played the PSS acts out or describes the situation presented on the slip of paper she selected. Ask for another volunteer to play the PSS and talk to the client about what she has observed or been asked.

Continue in this fashion with each volunteer PSS then becoming the client to present the role play situation she selected from the container. Be sure to process each role play by asking the group to provide feedback/give constructive criticism.

8. **Group Discussion.** Sometimes children have accidents when they're left with a babysitter or at day care. Ask the group to come up with a list of things that a mother can do to choose a child care provider and help her child care provider take good care of her child. **Possible responses** include:

- Make sure that the child care provider has experience. Should she be properly certified? Discuss.
- Observe how the child care provider interacts with another child to see that she is treating the child kindly.
- Call up two references on the person or center to find out what other people's experience has been.
- Make a sheet of suggestions for the child care provider so she has specific information about your child.

Distribute and discuss **Handout #5**, Suggestions for Safety. Is this something the mother should leave with her child when she leaves the child with a new child care provider? Why or why not? Could/should trainees also adapt it for use as a flier that parents can hang or put on their refrigerator door for use by a baby sitter who cares for their child in their home when they are out (at work, at school, at a movie, etc.)? Do they feel this handout would be easy to adapt for a sitter? How might they go about it?

Working as a group, ask trainees what suggestions they would make. For example, instead of "My telephone # is," trainees could put "My mother (parent) is at.....(place) and can be reached at.....(telephone number), or "My mother is at the movies. If you need help, call her sister, my aunt Gladys, at....."

When you have finished, suggest that participants may want to make a copy of this adapted version, so they'll have both to share with clients who need child care for their babies.

H. PRACTICE SESSION: ROLE PLAYS AND CASE STUDIES (1 hour)

Rationale: Participating in role plays will assist the PSS in integrating the information presented. This type of exercise will give some practice with "real life" situations.

Procedure: 1. **Case Study.** Ask trainees to find a partner. Pass out to each group one of the case studies and the list of discussion questions from **Training Aid #8.** Explain that each of them has received a "case" that tells about a situation facing a PSS making a home visit. Each case should demonstrate one of the points covered in this unit. Participants should use the discussion questions to talk the case over with each other and decide on a strategy for the PSS.

You may want to begin by using the example case to show the group how the questions should help them form a strategy for the PSS. Then give the group about 15 minutes to go over their cases.

Then ask a pair to present their case to the group. They may choose to discuss or perform their case before the group. Process the situation or role play by discussing the reasons the "PSS" responded the way she did in each case.

I. SUMMARY AND REVIEW (15 minutes)

Procedure: 1. Ask a person in the group to summarize the session. Or, refer back to the objectives and re-word them as questions, asking trainees to take turns responding.

2. Distribute and ask participants to complete or discuss a post-unit evaluation.

3. Distribute post-unit test.

Adapted with permission from Resource Mothers. 1993.

INFANT STATES AND PARENTS RESPONSES

When a mother notices that her baby is: she can:

1. sleeping ______________________________
____
2. quiet and alert ______________________________
____
3. crying ______________________________
____
4. looking at her ______________________________
____
5. quiet and sleepy ______________________________
____
6. fussy ______________________________
____

Adapted with permission from
Resource Mothers. 1993.

WHAT YOUR NEW BABY WILL DO

Your new baby will sleep about 17 hours a day. By the age of 4 weeks, the baby will be awake more often.

Your new baby will know your voice. The baby will watch your face when you talk to him/her

At two weeks of age, your new baby may begin to coo.

Your new baby will lift his head and move it to one side when laid on his stomach.

Your new baby will hear sounds. Your baby will turn her head to find you in the room.

When you place your finger in her hand, your new baby will grasp and tightly hold it.

Your new baby will be more alert in a darkened room.

Your new baby will need to be held, loved, and talked to - YOUR BABY CANNOT BE SPOILED!

Your new baby will have up to 5-6 soft, green to yellow stools each day.

Your new baby will sneeze to clear her nose.

Your new baby will spit up often, when burped.

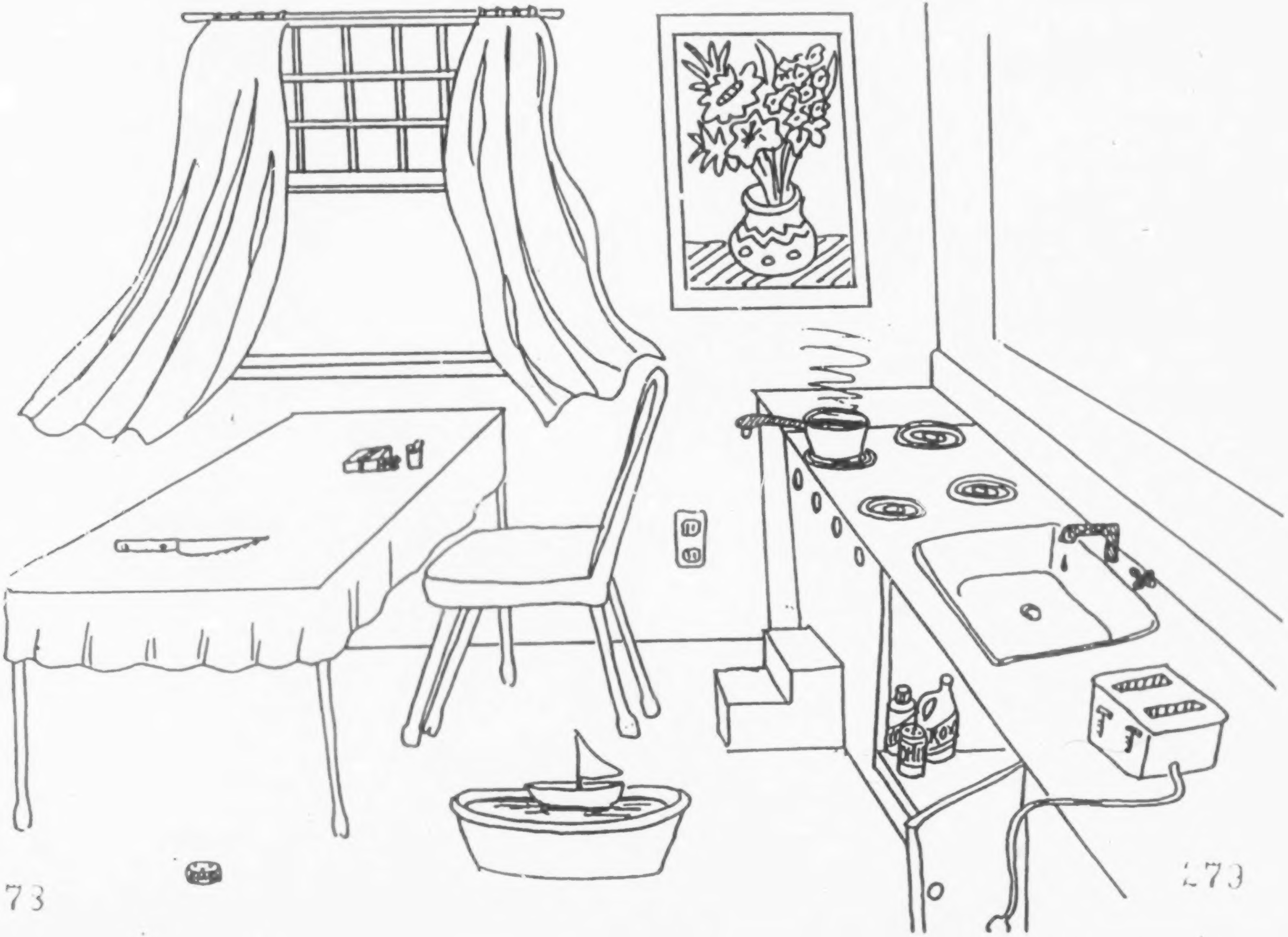
Your new baby will pass gas and hiccup.

Your new baby will cross his eyes sometimes.

* Please substitute the correct pronoun depending on the sex of the baby.

From: Indiana University School of Nursing, Maternity Outreach Mobile (MOM) Project Manual, Indianapolis, IN, 1990.

KITCHEN HAZARDS



This Belongs to:

Your Phone Number:

Emergency Numbers:

Write important phone numbers in the spaces below and tape this list near your phone.

Fire:

Rescue Squad:

Police:

Poison Control Center:

Special Thanks To:

American Academy of Pediatrics, American Red Cross, Children's Safety Network, Mary Ellen Fise, Massachusetts Statewide Comprehensive Injury Prevention Program, National SAFE KIDS Campaign™, Project PEACH, U.S. Consumer Product Safety Commission.

Illustrations by Bill Glascock
Cover Design by American Red Cross

healthy mothers, healthy babies™

This booklet was produced by the Injury Prevention Subcommittee of the National Healthy Mothers, Healthy Babies Coalition.

Home Safety Tips

You Can Keep Your Baby Safe

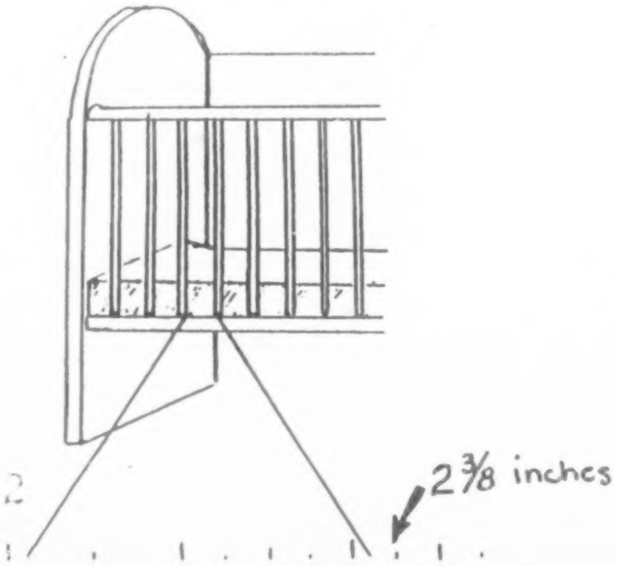
Adapted with permission from Resource Mothers, 1993.

Bedroom Safety

Hand-me-down and older cribs can be unsafe.

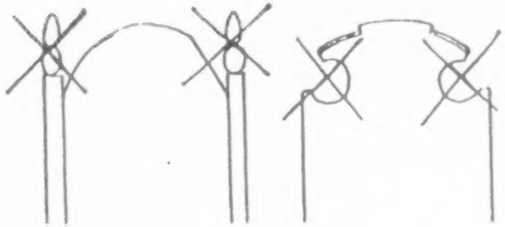
Is the space between the crib bars smaller than 2 3/8 inches? (If the space is too big, your child could slip through the space and strangle in between the bars.) Yes ☐ No ☐

✓ **TIP:** Use the ruler on this page to check. If the bars are too far apart you can weave cloth in between the bars to keep your child from falling through.

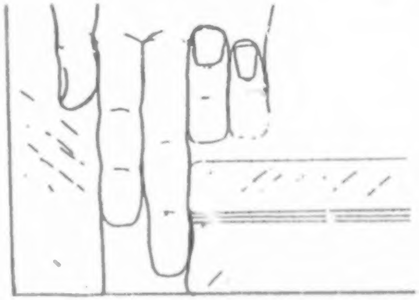


Are the corners of the crib level with the top of the crib rails, with no corner posts sticking up? Yes ☐ No ☐

✓ **TIP:** If you answered NO, unscrew the corner posts or saw them off so they are level with the top of the crib rails.



Does the mattress fit snugly against the sides of the crib so that no more than two fingers can fit in the space? Yes ☐ No ☐



✓ **TIP:** If you answered NO, place rolled towels between the mattress and the sides of the crib and check them each time you use the crib.

Adapted with permission from Resource Mothers, 1993.

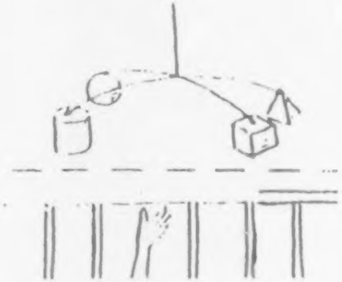
Is the mattress covered by a waterproof mattress pad, not a plastic bag or a garbage bag? Yes ☐ No ☐

✓ **TIP:** Children cannot breathe if they get a plastic bag over their nose and mouth. Use a waterproof mattress pad to protect the mattress.

Is the crib far away from electric cords, drapes and curtain cords? Yes ☐ No ☐

✓ **TIP:** Children can strangle if a cord gets around their necks. Move the crib away or tie the cord up so it is less than 6 inches long and out of your child's reach.

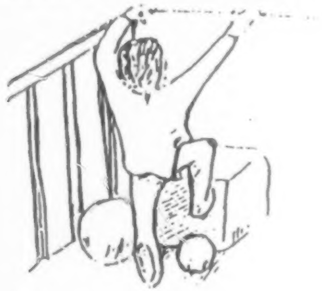
Are mobiles and hanging crib toys kept out of your child's reach? Yes ☐ No ☐



Are strings on crib toys and pacifiers removed so that children cannot be strangled? Yes ☐ No ☐

Were bumpers, toys and mobiles removed as soon as your child could push up? Yes ☐ No ☐

✓ **TIP:** If your child can push up, remove bumpers, and toys from the crib. Children will use anything they can to help them climb out of the crib. Your child can fall out of the crib.



Does an adult always stand next to the child with a hand on the child when the child is on anything above the ground (changing place or bed)? Yes ☐ No ☐

✓ **TIP:** Your child could roll over while being changed and fall. Gather things you need before you start changing the baby. If you forget something, take your baby with you while you get it.

dapted with permission from

Bathroom Safety

Children can't tell what is medicine and what is candy. They may try to eat anything.

Are medicines, vitamins, and cleaning supplies stored out of reach in locked cabinets? Yes ☐ No ☐

✓ **TIP:** If your child swallows something they should not, call a poison control center right away.

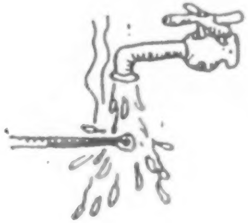
Electric items can cause an electric shock if they fall into the sink or bathtub while they are plugged in.

Are hair dryers, space heaters and other items always kept away from the water and unplugged after you use them? Yes ☐ No ☐

Young children have tender skin and are easily burned if the tap water in the sink or bathtub is too hot.

Does an adult always test the water with an elbow before putting a child in the tub? Yes ☐ No ☐

✓ **TIP:** Very hot tap water can cause burns. Check your hot water temperature.
Run hot water for 3 minutes.
Use (meat or candy) thermometer to check the temperature.
The temperature should be 120°F or less. If the water is too hot, talk to your landlord about lowering the temperature or installing an anti-scald device or lower the temperature yourself.

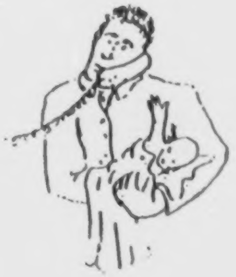


Adapted with permission from

Children can drown in very little water. They can even drown in the toilet, in a bucket, or in the bathtub. They can turn on the hot water and cause burns.

	Yes	No
Does an adult always stay with the child while he or she is in the bathtub? (Do not ask older children to watch younger children in the bathtub.)	☐	☐

✓ **TIP:** Take your child with you if you have to answer the phone or doorbell while your child is in the tub. NEVER leave your child alone or with an older child in the bathroom or tub, not even for a minute.



Kitchen Safety

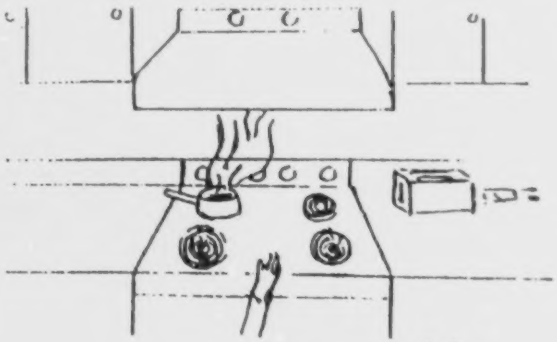
Children are curious. They will grab onto anything they can reach (appliance cords, mugs, pot handles or table cloths).

	Yes	No
Are coffee and tea mugs and other hot foods kept out of reach (away from the edge of a counter or table)?	☐	☐

✓ **TIP:** Many children are burned by hot liquids their parents are holding. Put your coffee or tea cup down before you pick up or hold your child.

	Yes	No
Are pot handles always turned toward the back of the stove?	☐	☐

✓ **TIP:** It is a good idea to use the back burners on the stove for cooking.

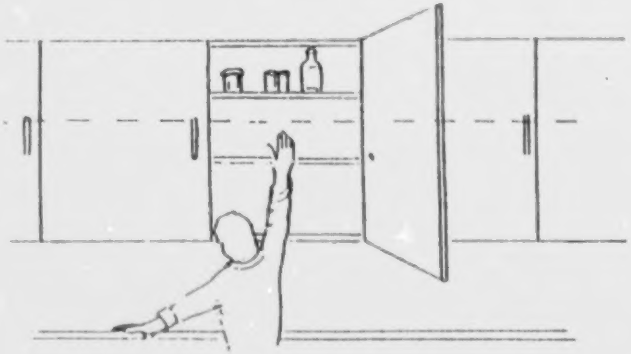


Adapted with permission from

Are appliance cords kept wound up and out of reach? Yes ☐ No ☐

Young children do not know what they should not put into their mouths. They also try to copy adults "taking medicines."

Are matches, cleaning supplies, medicines, and vitamins stored high out of reach in locked cabinets? Yes ☐ No ☐



Children under 4 can choke on round, firm foods like grapes, peanuts, hot dogs, raw carrots and hard candy.

Are these foods kept away from young children? Yes ☐ No ☐

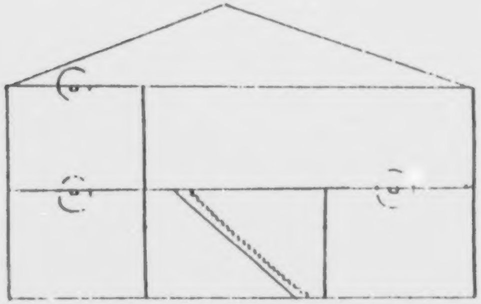
General Safety

A working smoke detector gives you and your family extra time to get out of your home if there is a fire.

Are there working smoke detectors on every floor of your home? Yes ☐ No ☐

✓

TIP: Smoke detectors should be placed on the ceiling or high up on walls outside all sleeping areas. You can buy smoke detectors in your local hardware store. They usually cost $6 to $25. Check with your local fire department. They may have free smoke detector programs.



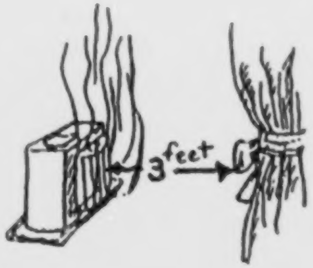
Adapted with permission from

Do you test every smoke detector once a month? Are the batteries replaced every year? Yes ☐ No ☐

✔

TIP: Use the test buttons on your smoke detectors to test them. Replace old batteries. Never remove the batteries for use in toys or radios.

Are space heaters kept at least three feet away from crib, beds, clothing, curtains, furniture and paper? Yes ☐ No ☐



Are matches and lighters locked in a cabinet that is higher than your shoulders? Children as young as 2 can start fires with lighters. Yes ☐ No ☐

Toys meant for older children may have

- **small parts**
- **batteries**
- **electrical parts.**

These can hurt young children.
Children may also choke on balloons, even pieces of balloons that have broken.

Are these toys kept away from infants and younger children? Yes ☐ No ☐

Other hazards to watch for:

Are plastic bags kept away from young children? Yes ☐ No ☐

Are alcohol and cigarettes kept away from young children? They are poisonous. Yes ☐ No ☐

Are guns and other firearms kept out of the house? Yes ☐ No ☐

✔

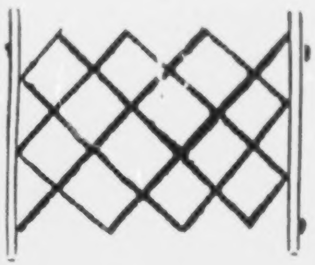
TIP: Do not keep guns and other firearms in the house. If guns are in the house, unload them, lock them up and keep the keys out of your child's reach. Store the gun separate from the bullets.

Adapted with permission from

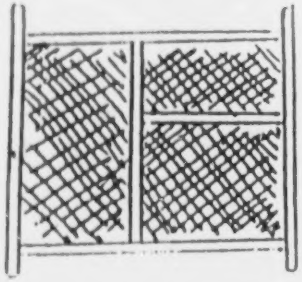
Are toddler gates used at the top and bottom of stairs? Yes ☐ No ☐

✓ **TIP:** Gates with big spaces between the slats should not be used—children can get trapped in the openings.

NO



YES



Are all plants placed out of your child's reach? Some house plants are poisonous. Yes ☐ No ☐

✓ **TIP:** Call your local poison control center to find out if your plants are poisonous.

Are children kept away from open windows to prevent falls? Yes ☐ No ☐

Do you have window guards to keep children from falling out of the window? Yes ☐ No ☐

✓ **TIP:** Screens are made to keep bugs out but are **not** strong enough to keep children in. Move chairs and other furniture away from windows to keep children from climbing near the window.
It is safer to open windows from the top so children cannot climb out.

Congratulations!!

By reading this booklet you have taken important steps to keeping your children safe.

There are other things that you can do to keep your children safe, like using a car safety seat every time your children are in the car. Check with your doctor or clinic for other safety tips.

Adapted with permission from
Resource Mothers 1993

SUGGESTIONS FOR SAFETY

My name is: ______________________________

I live at: ______________________________

My telephone number is: ______________________________

If my parent or guardian is needed, please call:

Name	Telephone Number

My Doctor's Name and Number are:

____

I am allergic to:

____

I am precious to my mother; please do the following to keep me safe:

- Always stay with me when I eat, to make sure that I don't choke on my food.
- Always hold me while you are changing me so I don't roll away and hurt myself.
- Supervise me closely, I don't know what is dangerous.
- Treat me kindly and I will always be kind.

Adapted with permission from Resource Mothers, 1993.

SLEEP AND AWAKE STATES

QUIET SLEEP

ACTIVE SLEEP

DROWSY

ALERT (Quiet or Active)

FUSSY

CRYING

Adapted with permission from
Resource Mothers, 1993.

CALMING A BABY

All babies cry. Calming a crying baby may be hard to do. Start with one action at a time. Doing it over and over again (repetition) works best. If what you try is not working, add one more soothing action and do it over and over again.

Try these ideas:

Check diaper

Check if hungry

Burp the baby

Check if too hot or too cold

Nurse the baby

Show baby your face

Gently hold both of your baby's arms close to his or her body

Rock, walk, or take your baby for a buggy or car ride

Let your baby suck on a pacifier

Talk to your baby in a steady, soft voice

Pick up and hold your baby close

Sing, hum or croon to your baby

Wrap your baby snugly (not tightly) in a blanket

Stroke one area of your baby's body such as the head, foot, or back

Take baby into a different room or outside

Turn off radio or TV or move to a quiet room

Take off baby's clothes and check if a pin or tag is sticking or rubbing skin

Check if a hair is wrapped around baby's toe or finger

Hold baby against you, skin to skin

Massage baby

Carry the baby in a soft baby carrier

Take a bath with your baby

From: Nursing Child Assessment Satellite Training (NCAST) "Keys to Caregiving, Booklet 3: State Modulation," Seattle, WA, 1990 and Boehle, D., "When Babies Cry," La Leche League International, No. 20, January, 1991.

CASE STUDY: HELPING A MOTHER COMFORT HER BABY

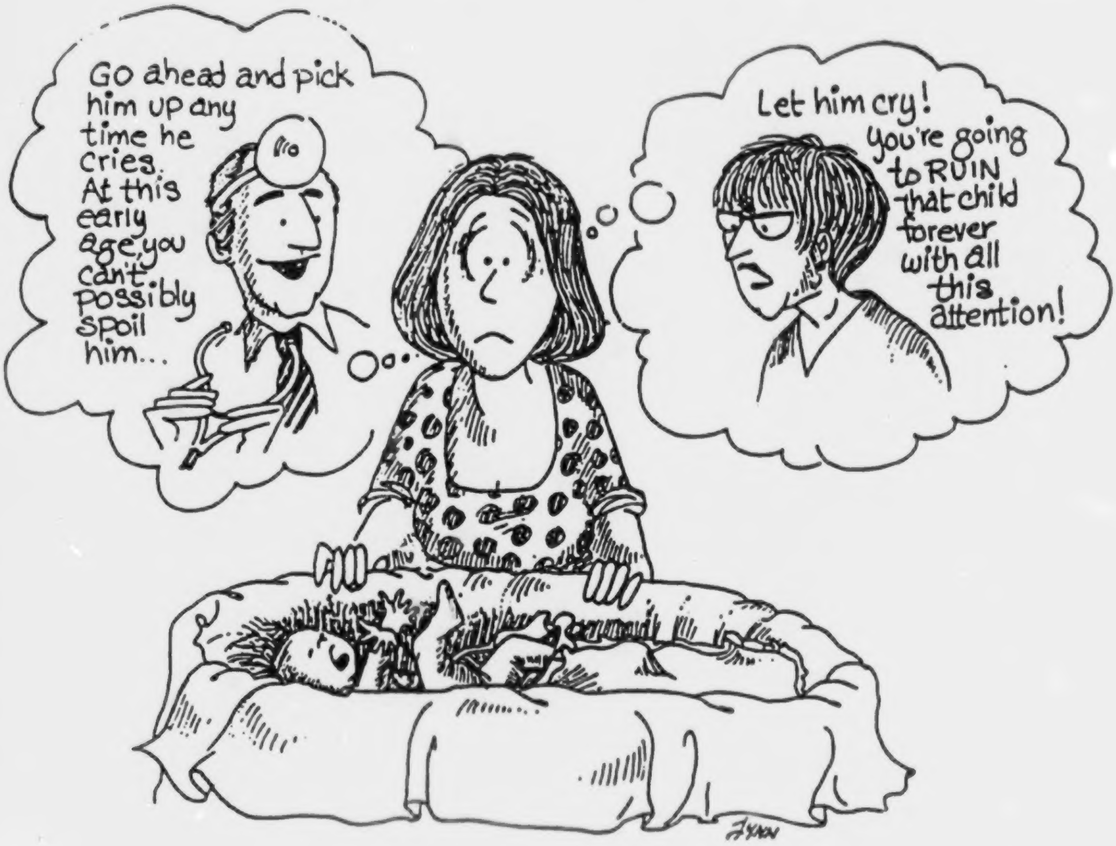
You, a newly trained PSS, have scheduled a 2:00pm home visit with Clarissa, a new mother. She has a four week old baby girl, Catherine. When Clarissa answers the door she is still in her bathrobe and her hair is uncombed. You can hear the baby crying from the crib in the bedroom. Clarissa looks surprised to see you -- she forgot about your visit! She is embarrassed about not being dressed. When you ask her how she's doing she sounds totally exasperated, "Catherine hasn't stopped crying for an hour. I changed her diaper, I fed her. I think I'll lose my mind if I have to keep listening to that screaming."

1. Discuss some of the things that appear to be happening in this case study before you arrive.
2. What can you say to help Clarissa feel better about herself?
3. What suggestions can you give Clarissa for calming her baby?
4. Should you show Clarissa how to calm the baby? Why or why not?

Adapted with permission from Resource Mothers, 1993.

BEST COPY AVAILABLE

TO HOLD OR NOT TO HOLD


Go ahead and pick him up any time he cries. At this early age, you can't possibly spoil him...
Let him cry! You're going to RUIN that child forever with all this attention!
Lynn

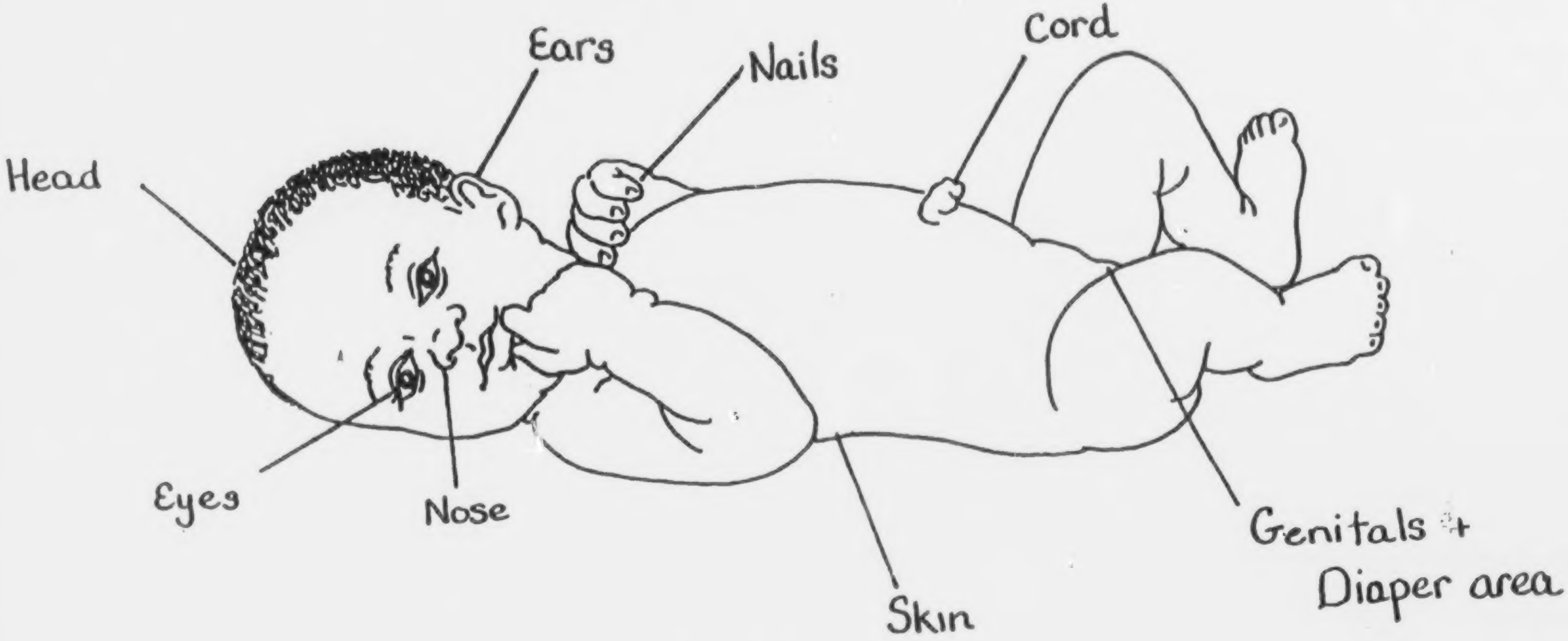
What is your opinion?

Illustration taken from Do They Ever Grow Up? and Hi Mom! Hi Dad! c. Lynn Johnston with permission of Meadowbrook Press, 18318 Minnetonka Blvd., Deephaven, MN 55391. Books $5.95 each. Orders: 800-338-2232. Add $1.25 for first book ordered, 50 cents each for every book thereafter, for shipping.

From: Weitzberg, B., "Exploring the World of Infants and Toddlers, A Training Manual About Infants, Toddlers and Their Parents," Friends of the Family, Inc., Baltimore, Maryland, 1993.

BABY CARE NEEDS

Describe – and then practice modeling – the care that is given to each of the body parts listed below.


Ears
Nails
Cord
Head
Eyes
Nose
Skin
Genitals + Diaper area

Adapted from: Mississippi State University and EFNEP, Expanded Food and Nutrition Education Program Partners for Life. "Partners for Life: A Maternal and Infant Nutrition and Health Curriculum".

Adapted with permission from Resource Mothers, 1993.

TAKING CARE OF A BABY

[Reminder: This information supplements - but does not repeat - procedures and advice given in the *Resource Mother's Handbook.* So first consult the *Handbook.*]

1. Additional notes on bathing a baby.

   - See instructions on pp 229-230 of *Resource Mother's Handbook.*
   - Support the baby's head and body with one hand and arm, and use the other hand to wash her/him (as illustrated on page 230 of the *Handbook*).
   - Remind new moms that wet babies can be very slippery, so they should hold their baby firmly.
   - Clean well between creases and skin folds.
   - Bathing a baby too often can dry baby's skin.
   - Cleaning or washing a baby who is sick will not harm her/him as long as they are kept warm.
   - The penis of an uncircumcised male baby should be cleaned with soap and water just like the rest of the diaper area. Initially, the foreskin is connected to the head of the penis so a mother should not try to retract it. After several months to years the foreskin will separate naturally. A mother can ask her health care provider to tell her when this has happened. After this separation occurs she may occasionally retract the foreskin to clean the end of the penis. An older child will need to be taught how to do this.

2. Care of the umbilical cord (navel/belly button) and penis (of a circumcised male).

   - See page 231 of the *Resource Mother's Handbook.*
   - Do not cover the navel.
   - Do not put a band-aid or adhesive bandage over the umbilical stump, because this can cause the moisture to accumulate. This, in turn, can cause infection.

3. Skin Care

   - Some oils can cause rashes. If a baby has dry skin ask the baby's health care provider to recommend a lotion.
   - Many babies have little white pimples (called milia). They are harmless and disappear with time. Tell moms not to break them, as this could cause infection.
   - See page 322 of the *Handbook* for information on protecting skin from sunburn.
   - In warm weather, do not use clothing that is too heavy. Babies can get a rash or red spots (prickly heat) from too much heat.

Adapted from: Meister, J. and Gvernsey de Zapler, J., Un Comienzo Sano, Training Curriculum, Class 10, University of Arizona, 1986.

4. Changing diapers

- See pages 228-229 of the *Resource Mother's Handbook*
- Wiping female babies from front to back helps prevent urinary track infections.
- Additional instructions for parents who decide to use cloth diapers.
  - Have at least six dozen on hand.
  - Use plastic pants or diaper covers to prevent urine from soaking through to clothing.
  - Wash excrement out of the diaper (in the toilet bowel) right after changing and before putting diaper in covered pail.
- After handling and changing soiled diapers, ALWAYS wash your hands with soap and water.

5. Dressing an infant

- See page 227 of *Resource Mother's Handbook.*
- Dress baby in clothing that is appropriate for the weather/season.
- One-piece sleepers or coveralls with snaps are easy to use in the early weeks/months of life.
- Be careful to support the baby's head when changing positions to get her arms in sleeves or to put on anything that goes over the head.
- Have whatever clothes you will need ready before beginning to dress baby. Never leave baby unattended on a bed or table.

6. Swaddling an infant.

- See pages 225 and 227 of *Resource Mother's Handbook.*

- When putting your baby to sleep, be sure to put him on his side or back and not on his stomach as used to be advised.

7. Soothing and comforting a fussy baby.

- See pages 224 - 227 of *Resource Mother's Handbook.*

8. Taking a baby's temperature.

- Instructions for both the rectal and armpit (axillary) methods are provided on pages 240 - 242 of the *Resource Mother's Handbook.*

Adapted with permission from
Resource Mothers, 1993.

SAFETY ROLE PLAYS
WHAT SHOULD A PARENTING SUPPORT SPECIALIST SAY?

You see a mother leaving her child on a changing table to wet a washcloth. What should you say?

....

A mother calls you to ask you if poinsettias are poisonous because her child has just eaten some. What do you do?

....

A mother has just called to tell you that she bought a beautiful old crib at a garage sale. What do you tell her to do?

....

You watch a new mother making formula from warm tap water first thing in the morning. What do you say?

....

An older child regularly leaves pieces of his toys around the room where a younger baby plays. What do you say?

....

A babysitter puts a pacifier on a string around the child's neck so the child won't lose it. What should you do?

....

When you call one day the mother tells you the child is alone in the bathtub. What should you do/say?

....

You visit a client whose baby has free range of the house at all times. What should you say?

....

Adapted with permission from
Resource Mothers, 1993.

CASE STUDIES

In the following scenarios, what could the PSS do/say?

1. Your client Shana won't give her baby Jasmine a pacifier. Instead whenever Jasmine is fussy, Shana just picks her up and lets Jasmine breastfeed. It works to calm and quiet her! Shana said a friend is teasing her and told her she was using her breast as a pacifier. Shana is worried that she might not be doing the right thing.

2. Marta says her ten month old Luis doesn't understand "No." He keeps going for the electrical socket again and again. Marta says it's making her husband Alberto really angry. He slapped Luis's hands but even that didn't stop him. Marta is worried that her husband will get so frustrated he will give Luis a huge spanking.

3. During a home visit, your client April, the mother of 11 month old Annie, tells you, "My Mom said I was toilet trained at 12 months. I think I'll start toilet training now." What should you say to Annie?

4. During a home visit, your client Robbie says to you, "Of course it's risky not to have Ben vaccinated but everything these days is risky. Especially in this neighborhood. You can walk down the street and get shot or run over by a speeding car. So why worry. I don't see why you're worrying, because I'm not." What will you say to Robbie?

5. Angel is a new teenage mother, living on her own. You are making your second visit to her since the birth of her baby boy Conner. When you enter the house it smells bad. There are some dirty diapers sitting on the floor. The baby's diaper is also dirty. As you watch Angel change the baby, you notice that the baby is still dirty when she puts on the clean diaper.

6. You are visiting Claudia, mother of eleven month old Rita. Rita has just started pulling herself up and reaching to grab things on table tops. You notice some serious hazards in the room...cords from heavy appliances hanging within reach and breakable objects on low tabletops. Claudia sounds frustrated when you arrive. She announces, "Rita broke a glass yesterday...I don't know what to do. I feel like she is taking over my house. She is going to have to learn not to touch my things."

7. Jeannie is a nervous mother. She seems to worry about everything. When you make a home visit two weeks after Danny is born she tells you that his umbilical cord has fallen off but she is afraid to bathe him. He was circumcised and she is afraid to get him wet.

8. You are visiting Dawn who has a two month old baby Cecilia. "She is impossible! Everyday from four to seven she screams. I can't do anything right. Sometimes I just feel like shaking her!"

Adapted with permission from Resource Mothers 1993

Use these questions to guide your discussions:

1. What have you learned about the parent's point of view? How does he or she see things? (summarize what the parents said)

2. What can the PSS do to support both the parent and the child in the situation?

3. What can the PSS say to the client?

4. What types of modeling, if any, should the PSS do?

Sample Case Study with Questions Answered

During a home visit, your client Gena, mother of six month old Kelly, says to you, "My Kelly loves to sit and watch TV you know. I put her in the infant seat and she'll just sit there forever. I think it's really good for her to watch TV because it will help her be smart, seeing all those new things and all the colors. I think she likes it. My Dad never had a TV and he is not too smart.

1. *What have you learned from Gena?*

Gena is concerned about her baby's development.
She believes that passive TV watching is productive for the baby.
Gena may have a poor self-image, especially as she views her father as "not too smart".
Gena believes that she is doing what is best for her baby. She sees propping Kelly up in front of the TV as a good way to keep her occupied.

2. *What can the PSS do to support both Gena and her child in this situation?*

The PSS can praise Gena for being concerned about her child's development. At the same time the PSS can help Gena understand that babies develop through interaction. Television does not give a baby a chance to respond. When a mother smiles and talks at her baby, the baby has a chance to respond with movements and sounds.

3. *What can the PSS say to Gena?*

"Have you noticed how Kelly watches you when you talk? She is really listening to you."
"Kelly really moves her arms and legs and reaches for you when you hold that rattle out for her."
As Gena responds, the PSS may also want to discuss the baby's need to interact with a parent or other person in order to develop language and other skills. The PSS could encourage Gena to think up ways in which she could do more to help develop language, social, and thinking skills in her baby.

4. *What types of modeling, if any, should the PSS do?*

The PSS can show Gena how to sing a song, like pat-a-cake, with the baby...etc.

Adapted with permission from Resource Mothers 1993

UNIT 11
POST-UNIT TEST

1. Describe 3 physical characteristics of the newborn.

2. Describe 3 techniques used to comfort a baby.

3. Describe how a parent can tell if a baby is sick.

4. Describe 5 safety hazards in the home and for each one, ways to "baby proof" the environment.

5. Refer to the immunization chart in the RM Handbook page 234 and list what immunizations are need at:

   2 months: ______________________________

   6 months: ______________________________

   6 to 18 months: ______________________________

Adapted with permission from
Resource Mothers, 1993.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

Adapted with permission from
Resource Mothers, 1993

POST-UNIT EVALUATION

UNIT COVERED: _____

DATE_______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

Adapted with permission from Resource Mothers. 1993.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

*Adapted with permission from
Resource Mothers, 1993.*

Unit 12
CHILD GROWTH AND DEVELOPMENT: INTRODUCTION

During their first year, babies grow faster, both physically and emotionally, than during any other time of their lives. Babies need food and physical care along with help and encouragement through every stage of development to thrive and grow into strong, healthy, and confident people.

Most parents try to do the best they can for their children even when there are adverse circumstances. PSSs can help support parenting efforts by providing emotional support, by helping parents gain the knowledge they need to develop confidence and competence, and by linking them to health and social services and other community resources when needed.

Objectives

By the end of this unit, participants will be able to:

- Describe what is meant by physical/motor, cognitive, emotional, social and communication development.
- Discuss why it is so important for an infant to feel loved and cared for.
- Discuss how parents and caregivers can help infants develop feelings of security and trust.

Time

4 1/2 hours

Outline

A. Why Learn About Infant Growth and Development?
B. Building Blocks of Infant Development
C. Summary and Review

Materials

- Resource Mothers. (1993). Resource Mothers Curriculum Sourcebook (Ch. 12). Sterling, VA: INMED.
- Resource Mothers. (1993). Resource Mothers Handbook (Ch. 14). Sterling, VA: INMED.
- Video *"Your Baby and You: Understanding Your Baby's Behavior"*, Communication Skill Builders, 3830 E. Belleview, P.O. Box 42050, Tucson, AZ 85733.
- Weitzberg, B. (1992). Exploring the World of Infants and Toddlers: A Training Manual About Infants, Toddlers, & Their Parents. Baltimore, MD: Friends of the Family, Inc. (410) 659-7701.
- Shelov, S.P. & Hannemann, R.E. (Eds.) (1991). American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5. N.Y.: Bantam Books.
- Child Development True/False Quiz **(Handout #1)**.
- Post-Unit Test **(Handout #2)**
- Role Plays **(Training Aid #1)**
- Role Play Feedback **(Overhead #1)**
- Post-Unit Evaluation
- Program policies regarding child abuse and neglect.
- Program policies concerning confidentiality.
- Blackboard and chalk or newsprint, markers and tape.
- Video Equipment: video camera, tripod, tape, television, VCR.

Adapted with permission from Resource Mothers, 1993.

Advance Preparation:

- Review Chapter 14, "Child Growth and Development" of the Resource Mothers Handbook and ask trainees to review it ahead of time.
- Review Resource Mothers Curriculum Sourcebook, Unit 12, Child Growth and Development.
- Review video: *Your Baby and You: Understanding Your Baby's Behavior.*
- For background information, review *Exploring the World of Infants and Toddlers*.
- Make sufficient copies of any handouts to be used.
- Review and bring the group a copy of *Caring for Your Baby and Young Child: Birth to Age 5*.
- Have several special pictures, sayings, poems about babies and their development. Two suggestions are:
  Leach, P. (1990). Your Baby and Child, Birth to 5 Years, (pp.9-12). N.Y.: Alfred Knopf.
  Bermont & Langston (1965). The Child. N.Y.: Pocket Books, INC.
- Try out video equipment. Set up camera to videotape role plays.

Adapted with permission from
Resource Mothers, 1993.

A. WHY LEARN ABOUT INFANT GROWTH AND DEVELOPMENT? (1 1/2 hours)

Rationale: PSSs are parents themselves and have lots of practical knowledge of infant growth and development. Just like the PSSs, most parents learn how to care for their infants through "on the job training." It is important to establish in the beginning of this unit why learning some principles of infant growth and development can benefit PSSs and their clients.

Procedure: 1. Use special pictures, sayings or poems to begin this unit.

2. **Activity. True/False Quiz.** Distribute the Child Development True/False Quiz (**Handout #1**) and ask participants to take five or ten minutes to complete it. If participants have difficulty reading, you can administer the quiz verbally. Reassure participants that this is not a test of their knowledge and the papers will not be collected.

When participants have finished, read aloud each of the statements and ask them to raise their hand each time you read a statement they believe to be true. Encourage discussion and provide correct answers and rationale only after each item is discussed.

3. **Discussion.** Ask participants who have children to try to recall their feelings when their children were infants. Looking back, was there ever a time when they worried about something their baby didn't seem to do as soon as other babies -- like smiling, rolling over, sitting up, talking, sleeping through the night, or walking? Some mothers may not have been concerned when their babies achieved these developmental milestones. Other mothers may have worried that their child was "slow" or behind other children they knew. If you have children, you may want to "get the ball rolling" by sharing one or two concerns about your own child's development.

4. **Discussion.** Now ask participants what can sometimes happen when parents don't understand the emotional and physical capabilities of their children. **Possible answers:**

- Parents can get angry and frustrated with the child.
- Parents can feel inadequate.
- Parents might push the child to do something they aren't yet ready to master and instead of enjoying the exhilaration of learning something new, the baby becomes frustrated and stops trying.
- Babies may be held back from mastering more difficult skills for which they are ready.
- Baby's behavior may be misinterpreted as willfulness, stubbornness, or naughtiness.
- Parent may not recognize the need to help baby master basic skills.
- Parent may not recognize something is wrong with baby's development and get help as soon as possible.

Adapted with permission from
Resource Mothers, 1993.

5. **Discussion.** Ask participants who do parents in their community usually turn to for information and advice about child growth and development. **Possible answers:**

- family
- friends
- clinic

Ask if participants think there is a role for PSSs when it comes to helping parents understand infant growth and development. What is that role? **Possible answers:**

- listening
- answering questions
- observing
- offering support
- being a source of advice

Discuss what PSSs can do if the advice they give conflicts with advice given by another trusted source.

Discuss how PSSs will decide who to include in discussions about infant growth and development. How about involving members of the family besides the baby's mother, for example the grandmother, father, aunt, or godparent? Use Role Plays from **Training Aid #1.** Each PSS will need a partner. Each pair will act out the role play that they were given. Discuss the role plays with the whole group to get feedback after each pair is finished.

Reinforce the important role that PSSs can play in helping to support parents. Helping parents understand how to foster the healthy growth and development of their newborn is just one of many ways PSSs can assist new parents.

6. **Activity: Designing Objectives.** Again, let the participants know how much you value their knowledge and experience. Ask them what they would like to learn about infant growth and development. What would help them in their roles as PSSs? Write their suggestions on the blackboard or newsprint. Be prepared to modify your agenda based on their perceived learning needs.

B. BUILDING BLOCKS OF INFANT DEVELOPMENT (3 hours)

Rationale: In this unit, participants examine five basic areas in which infants grow and develop skills during the first twelve months of life. Participants will also discuss how the development of trusting relationships can foster development in all five skill areas.

Refer to the definition and explanation of 'trust' in RM Handbook. This unit presents the idea that a baby is a 'person-in-the-making' and that there are many factors that can impact development.

Adapted with permission from Resource Mothers, 1993.

Procedure: 1. **Mini-lecture and discussion.** In Chapter 14 of the Resource Mothers Handbook, four general areas in which babies grow and develop skills are explained. Ask if anyone can name them. The Resource Mothers Handbook includes Communication (speech and language development) in the Cognitive area. We are going to look at Communication as a separate, fifth area of development. **Responses** should include:

- **Physical/motor** development (physical movement for stability and mobility as well as finer movements of the arms and hands for play and self feeding)
- **Cognitive** development (thinking, memory, responding to the world with one's senses ie.smelling, touching, hearing, tasting)
- **Emotional** development (self-esteem)
- **Social** development (responding and reaching out to others)
- **Communication** development (understanding and expressing)

With each developmental area give examples of skills in that area and ask for ideas from the participants as well. Include ideas of developmental milestones and developmental progression of skills.

For each of the five developmental areas have a different colored square of paper. Post these on a blackboard or flip chart. Explain that these skills are all interrelated, which means that one skill can affect one or more of the others. This is especially true during the period we are talking about, Birth to One Year of Age. Give one example of how skills are interrelated, such as a baby seeing her mother and reaching up to touch her. The baby sees (cognitive), extends her arms to touch her mother (physical), and responds to her mother by reaching for her (social, emotional, and communication). Ask trainees to give other examples from their personal experiences.

Write skills on individual post-its. Have participants place each skill in the area in which it belongs; ask if the skill really fits in more than one area.

Discuss how one activity can elicit skills in many areas and how a skill in one area can facilitate skill development in another area.

2. Discuss how a parent's actions can help or hinder normal growth and development. Possible points for discussion:

- ♥ **Infants need to feel they are loved and cared for.** During the first couple of years, children have a strong need to develop close, loving attachments with a few special adults in their lives. Some experts label this important social task as the development of trust. Feeling secure and loved helps a child with all other stages of development.

- Ask how parents can help their infants feel loved and secure.

Adapted with permission from
Resource Mothers, 1993.

- Respond quickly and consistently to the baby's needs. In the first several months, it is impossible to spoil a baby. Ask the group if they agree with this and discuss their reactions. (Also see Unit 11, Baby Care.)

- Provide consistency. Babies do not require absolute consistency, but establishing some regularity in routines, environment, and responses helps baby to feel that life is predictable and secure.

- Show love and affection often. There are many, many ways to do this. Ask the group to name some (smiling, holding, singing, rocking, patting, admiring, carrying, etc.). Even at very young ages children imitate the people they love. Newborns imitate adult facial expressions. One of the most important jobs of a parent is to reflect back to the child his or her instinctive joy. Children are naturally full of joy and love. PSSs -- and parents and grandparents -- have an opportunity to make this world a better place by helping children hold onto these instincts, rather than becoming distrustful and fearful. You may also want to discuss that it is sometimes hard to love a baby -- especially if the baby is fussy or colicky and doesn't fulfill a parent's expectations. It can also be difficult if parents are stressed by other pressures in their lives. Learning to show love is an important task for new parents.

- Try to understand what the baby is attempting to communicate. Get to know what makes baby happy and miserable. If the baby arches his back and pulls away from the adult that is holding him, he may be telling that adult that he is over stimulated and needs a rest in a quiet room away from bright light, noise and other extraneous stimulation. Ask the group for other examples.

♥ **Help the infant develop specific skills.**

- There are many ways parents can help their babies develop specific skills. Most new skills in the early months will emerge without help from parents -- skills like sucking and swallowing, learning to use arms and fingers, learning to crawl and then walk. But there are many, many toys and games that can assist in infant development and help babies and parents enjoy the time they spend together.

- Providing positive reinforcement is another way to encourage baby in skill development. "Wow. Look at you! Aren't you having fun? What a strong baby!"

♥ **Encourage interest in the outside world by stimulating the infant's curiosity.**

- Children discover very early that learning is fun. The child who learns to enjoy his or her early attempts at exploration and who meets with positive reinforcement will develop curiosity and a true joy in learning. One way to foster that interest in the outside world is to provide activities that interest and stimulate the baby.

Adapted with permission from Resource Mothers, 1993.

4. People who have never had loving, trusting relationships in their lives sometimes find it difficult to establish warm, loving relationships with their children. The PSS should be alert to signs that indicate parents are having difficulty forming loving attachments with their babies. Ask the group to name some signs to watch for. **Possible response:**

- parent ignores baby's cries
- baby's physical needs (food, dry clean diaper, clean clothes and bedding, safety, etc.) aren't met
- parent doesn't seem to enjoy baby or take an interest in his or her growth and development
- parent doesn't enjoy physical contact with the baby
- infant cries incessantly or not at all--as though he or she has given up
- baby has a vacant stare and doesn't attempt to make eye contact or reach out to parent in any way
- baby shows outward signs of physical abuse such as bruises, welts, and other unexplained injuries
- baby cries when parent comes near

Let participants know that if a PSS has concerns about the formation of trust and loving attachments between her client and baby, she should discuss the situation immediately with her Supervisor. Physical signs of abuse must be reported to the Supervisor immediately. Review the child protection laws of your state, your program policy regarding child abuse and neglect, and policies regarding confidentiality. You may have discussed these requirements in Unit 2 and will again in Unit 14, but it is prudent to review these guidelines again.

C. SUMMARY AND REVIEW (15 Minutes)

Procedure: 1. Rephrase the objectives on the first page of this unit as questions. Ask a volunteer to answer each question.

2. Distribute the post-unit evaluation forms.

3. Distribute post-unit test.

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CHILD DEVELOPMENT TRUE/FALSE QUIZ

Put a check by the statements you believe are true. This is not a test and will not be collected.

☐ Babies are born with the ability to see.

☐ Most babies are ready for toilet training by the time they are one year old.

☐ Picking up a two month old baby every time he cries can spoil him.

☐ Newborn babies are attracted to bright colors.

☐ At two months, if a baby smiles, it's probably due to gas.

☐ Playing loud music can damage a baby's ears.

☐ The five month old baby who doesn't respond to her mother's face and voice may have a problem seeing or hearing.

☐ You don't have to worry about a three month old rolling off a bed or changing table because they don't have the physical skills to roll over.

☐ Babies who are more advanced in one area, like language, may be slower in another area, like physical development.

☐ Two month old babies can be taught not to pull their mother's hair and jewelry.

Adapted with permission from
Resource Mothers, 1993.

POST-UNIT TEST

1. Describe what is meant by:

   a. physical/motor development: ______________________________

   b. cognitive development: ______________________________

   c. emotional development: ______________________________

   d. social development: ______________________________

   e. communication development: ______________________________

2. Why is it important for an infant to be loved and cared for?

3. Discuss how parents and caregivers can help infants develop feelings of security and trust.

ROLE PLAYS

Use each scenario for a pair of participants. One should be the client and one the PSS.

……

Grandparents have a lot to say about the baby and mom's care of her. They are visiting for a week from Michigan. Mom seems close to tears.

……

Godparent wants to be involved with the baby but seems inappropriate with the baby. Mom doesn't seem to know what to do.

……

Father seems uninterested in the baby but he does hang around while others are caring for the baby. Mother seems to want the father to be there and help out but she doesn't give him a chance.

……

Best friend of mom wants to talk about herself while you are visiting. Mom is distracted from what you are saying.

……

A 2 year old and a 4 year old sibling are running around and interrupting you and the mom. The mom keeps yelling at them to be quiet and go play somewhere else.

……

Maternal grandmother lives with the family. She has many of her own ideas about how to care for the new baby. Sometimes mom seems angry but doesn't say much.

……

Unit 13

IDENTIFYING FAMILY NEEDS AND ACCESSING COMMUNITY RESOURCES

Even though a primary responsibility for a PSS is to help women find and receive health care for themselves and pediatric care for their children, most women with newborns have many additional stresses in their lives. There are many services in your community that are available to the women who enroll in the PIP program. This unit will review some of those services and procedures to help PSS's identify needs of the families and provide strategies for accessing support.

Objectives

By the end of this unit, participants will be able to:

- Describe the social service agencies most frequently needed including:
  - WIC
  - AFDC
  - Medicaid
  - Foodstamps
  - Housing assistance
  - Public health clinics
  - Childcare
  - Legal aid
  - Educational/vocational training
  - Drug and alcohol treatment
  - Smoking cessation
  - Child development screening
  - Early intervention
- Help families identify service needs.
- Explain how the PIP team could work together to address a family's service needs.
- Know procedures for making referrals.
- Develop a plan for accessing resources in response to specified family needs.

Time

9 hours

Outline

A. Review Resource Guides and Handouts
B. Presentations By Agency Representatives
C. Developing a Resource Directory
D. Practice Conducting a Family Needs Assessment
E. Discuss Procedures For Accessing Services

Adapted with permission from Resource Mothers, 1993.

F. Obstacles to Following Up on Referrals
G. Discussion of Confidentiality
H. Summary and Review

Materials

- DC Telephone Directory
- DC CPH Mom's Resource Book
- DC Public Schools Early Childhood Organizations Service Directory
- UDC Boarder Babies Project Guide to Services
- Pride in Parenting Resource Manual
- Winton, P., Bayley, D.(1988). The Family Focused Interview: A Collaborative Mechanism for Family Assessment and Goal Setting. Journal of Division of Early Childhood, Vol.12, 195-207.
- Resource information Form **(Handout #1)**
- Survey of Family Needs **(Handout #2)**
- Model for the Family Interview **(Handout #3)**
- Family Needs Plan **(Handout #4)**
- Skills for Effectively Communicating with Families **(Handout #5)**
- Telephone Tips **(Handout #6)**
- Resource Mothers (1993). Handbook (Ch. 5). Sterling, VA: INMED.
- Developing a Referral Plan **(Training Aid #1)**
- Role play: Obstacles to Following Up On Referrals **(Training Aid #2)**
- Role Play Feedback **(Overhead #1)**
- Post-Unit Evaluation
- Post-Unit Test
- Video Equipment: camera, tripod, tape, VCR and TV

Advance Preparation:

- Read the *Resource Mothers Handbook*, Chapter 5, "How to Find Help in the Community."

- Read Winton and Bayley article "The Family Focused Interview..."

- Review the Survey of Family Needs Assessment **(Handout #2)**.

- Develop several sample Family Needs Assessments for use in role plays.

- Review Model for the Family Interview **(Handout #3)**.

- Invite 4 - 5 social workers and/or representatives of agencies or community organizations to talk about resources in the community. Ask them to prepare a five minute description of what type of service their agency offers and come prepared to distribute some written information to the group.

Adapted with permission from
Resource Mothers, 1993.

- Collect brochures to hand out to trainees describing any local services or organizations whose representatives are not attending your panel discussion.
- Give extra copies of the "Where to Get Help in Our Community" chart from the *Resource Mothers Handbook* to the panelists.
- Copy the chart from the *Resource Mothers Handbook* on to the board or newsprint so the group can complete it together.
- Ask the Program Coordinator to gather directories of agencies in the community with whom PSS's may be networking. Include name, contact person, address and telephone number.
- Ask the trainees to bring in their copies of the local telephone book.
- Cut up the Role Plays and have them ready to distribute.
- Set up video camera to record role plays.
- As an ongoing activity, try to arrange opportunities for Parenting Support Specialists to visit community agencies. Trainees may not be able to complete these visits during the course of training, but it would be helpful as an ongoing activity during the first few months on the job. See **Training Aid #2.**
- Make enough copies of Community Agency Checklist for each trainee.

Adapted with permission from Resource Mothers, 1993.

A. REVIEW RESOURCE GUIDES AND HANDOUTS (1/4 hour)

Rationale: While a Parenting Support Specialist is not expected to solve her client's problems, there are times when she can help by directing her client to available community resources.

Procedure: 1. **Mini-lecture and discussion.** This unit will cover resources available to clients, and how PSS' can help clients to make contacts and get the help they need.

2. Ask the group what the term "networking" means. Try to have everyone contribute some idea or example. Then summarize and develop a definition by explaining that it means making contacts and finding out what goes on in other agencies that might be useful to PSS and their clients. PSS don't need to know everything about a particular agency or service, but they should know where to go to find information about community resources.

3. Ask if any of the trainees have a "contact" with any of the community agencies that provide support to women and families in the community. List those organizations on the board or flip chart, along with brief information about what services those organizations provide. Ask the group to refer to their *Resource Mothers Handbook* and to find where each organization fits into the chart, "Where to Get Help in Our Community." Have the group fill in the name and address, contact person, and telephone number for these organizations (while the trainer or a volunteer fills in the large similar chart prepared in advance of the session.) Ask trainees if they know where to find that information in their telephone books. If they don't, direct them where to look. Explain that as they make contacts in the community, including the panelists coming to this training session, they can add names and addresses to this list.

B. PRESENTATIONS BY AGENCY REPRESENTATIVES (1 hour)

Rationale: An overview of valuable resources is helpful, but even more helpful is putting a face and name to a particular agency. It helps to build a true sense of network.

Procedure: 1. Introduce the panel and ask each panelist to give a brief description of his/her organization. When each panelist has finished speaking, encourage the group to ask questions. Fill in where each organization fits into the chart, "Where to Get Help in Our Community."

2. Be prepared for any negative questions or comments particularly if any of the PSS have had unfortunate experiences with any of the agencies.

3. Thank the panelists and ask them if they have any other contacts to add to the chart.

Adapted with permission from Resource Mothers, 1993.

4. Ask the panelists if they have anything else to add. Then thank them and ask the group to look at Chapter 5 of their *Handbook* while you escort the panelists to the door.

C. DEVELOPING A RESOURCE DIRECTORY (2 1/2 HOURS)

Rationale: Being able to guide families to appropriate service agencies for their needs is an important part of the PSS's job. Having resources at one's fingertips is important in facilitating intervention.

Procedure: 1. Ask the group how they might be able to fill in more of the chart begun with the panelists' information. **Possible responses** should include:

- Telephone book
- Toll free 800 numbers and hotlines to call for information, crisis support, and emergency help
- Social Service, Agencies and/or health departments that run public programs
- Women's centers
- Networking
- Site visits to other organizations in the community.

2. Use the phone directories for listings of offices of services offered by your local government.This is in addition to the information obtained from the panelists. Continue by gathering more resources from the phone directories and identifying other resources that might be needed that are not on the original list. Using the flip chart, list the resource in a column on the left, have the location of the office in a second column and a contact number in a third column. Divide the finalized list into sections so that each PSS will be responsible for completing resource information for a section of the list. Indiviuals may have preferences for which group of agencies would like to be responsible. Ask for this feedback.

3. Distribute the Resource Information Form (Handout #1) which the PSS's will complete for each agency that they contact. Describe each of the sections and questions they will need to ask in order to get the information. Have them note the different response styles of the people they talk to when getting the needed information. This is important so that they can prepare mothers for what they may experience in attempting to access resource.

4. Show the group resource directories currently available to assist in identifying services in their community for families and children. Due to budget cuts, services in these directories may no longer be available. Always check individual services before making a referral. Make the existing directories available to the PSS's to assist them in compiling current resources which will be leading to their own resource directory.

Adapted with permission from Resource Mothers, 1993.

5. Give participants an hour to begin collecting information. This task should be ongoing. It will likely work out best if the PSS's are given a large block of time perhaps after training and before the delivery of intervention begins.

D. PRACTICE CONDUCTING A FAMILY NEEDS ASSESSMENT (2 hours)

Rationale: For families to be empowered they must themselves learn to identify their needs and prioritize those needs into an action plan. The PSS can assist families in learning this process.

Procedure: 1. **Discussion.** Introduce the group to the Survey of Family Needs **(Handout #2)**. The Survey covers a broad range of needs that families with young children would be likely to have.

2. Have the group discuss the broad areas (financial needs, needs for information, etc.) and identifying which ones will be likely needs for the PIP families.

3. The survey can be completed by the family or filled out by the PSS in discussion with the family.

4. Demonstrate how information from the survey and from conversation with the mother can be organized into broad areas for discussion in developing a service plan.

5. Review the steps for the family interview to develop the family needs plan **(Handout #3)**. Describe the procedure for conducting the interview and the guidelines to discuss with the mother in setting it up. Emphasize the point of having the mother decide who else will participate, if anyone. Be sure to give assurances of confidentiality.

6. Distribute the Family Needs Plan (Handout #4). Discuss the way in which the PSS should list the needs, have the mother prioritize the urgency of each need and then develop the plan for how the need will be met. This entails who will take responsibility for finding resources to fill each need and a time frame for completion of each of the objectives. Use the following outline as a guide for completing the Family Needs Plan:

Developing a Family Needs Plan

Discuss family strengths
Review survey of family needs
Ask parent(s) to expand upon identified areas
Ask if other areas need attention
Develop a list of the needs and steps to achieve them
Prioritize needs with mother
Identify who will follow up on which needs and within what time frame

Adapted with permission from Resource Mothers, 1993.

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7. Review Skills for Effectively Communicating with Families (Handout #4)

8. **Role Play Exercise.** First demonstrate a role play of the family interview. Have the trainer play the PSS and one of the participants play the mother. The trainer will work from a sample Family Needs Survey that was prepared ahead of time in discussing with the mother the needs she has identified. Continue the role play by filling out a Family Needs Plan for this mother. Then divide the group into three and select three to be "mothers" and three to be interviewers. Provide each of the interviewers with one completed needs assessment and have them interview the "mothers" to develop a Family Needs Plan. Videotape 5-10 minutes of each pair.

Have the PSS's discuss what their experience was like in conducting the interview.

9. Replay some of the tape of each group and have the PSS's comment on what they observe.

E. DISCUSS PROCEDURES FOR ACCESSING SERVICES (1/2 hour)

Rationale: When serving families who have many needs, it is important that each PSS be comfortable with how to access the services clients may need.

Procedure: 1. **Exercise.** Ask each participant to write down on a piece of paper a problem situation that they themselves have had or that they think a client might have. Give one example, such as the following situation:

> Ronelle came here three years ago from South Carolina. Recently she and her partner broke up and he forced her to leave their small apartment. She has no family here and no place to live. She doesn't want to return home. Where can she go for help?

2. Then have trainees discuss the various organizations in your community's "network" that might be able to help Ronelle.

3. Give the group 5 minutes to jot down their problem situation that requires assistance from organizations in your community.

4. Go around the room and have each trainee read the problem situation they have written down. With the group, identify one or more resource organizations where the client should go for help.

5. Given a typical set of family needs have the PSS's develop a full referral plan **(Training Aid #1)**.

Adapted with permission from Resource Mothers, 1993.

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F. OBSTACLES TO FOLLOWING UP ON REFERRALS (1-1/2 hours)

Rationale: It is not enough to simply provide information. Parenting Support Specialists often need to guide clients and support them through the referral process.

Procedure: 1. **Discussion and Role Plays.** Begin by asking trainees why, in their opinions, clients might not follow up on referrals? **Possible responses:**

- Fear
- Misunderstanding
- Doesn't know where it is
- Doesn't know how to get there
- Doesn't know how much it will cost
- Doesn't understand how the service will help her
- Is not convinced that she can really use the service
- Discomfort on the telephone

2. Distribute and review **Handout #5**, Telephone Tips. Perhaps go around the room and ask each PSS to take turns reading each suggestion. Ask for additional ideas and have trainees add them to their lists.

3. Ask participants to break into teams of two and hand out different role plays (**Training Aid #2**) to each team. Ask them to practice performing the role plays and then ask for volunteers to present their "plays" to everyone. If you have access to a video camera, use it now, and play it back later so volunteers can observe themselves. When doing their role plays in front of the group, have the group provide constructive criticisms to each team. As the trainer, be sure to give lots of positive reinforcement. Emphasize that they should encourage the "clients" to make the calls themselves instead of doing it for them.

4. When everyone has finished, work with trainees on telephone skills. The exact issues to be emphasized will depend on what you observed during the role plays.

G. DISCUSSION OF CONFIDENTIALITY (3/4 hour)

Rationale: Recognize the importance of client confidentiality in communicating with agencies. Communication between PSS and mother is confidential unless the mother gives permission to share information.

Procedure: 1. Discuss types of information that would be confidential.

2. Discuss ways to seek information from agencies without divulging confidential information.

3. There are a few circumstances where certain information cannot be maintained in confidence (i.e. child abuse). Discuss ways to handle this circumstance.

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H. SUMMARY AND REVIEW (1/4 hour)

Procedure: 1. Rephrase objectives in form of questions and have participants answer questions.

2. Distribute Post-Unit Test.

3. Distribute and have participants complete the post-unit evaluation form.

Adapted with permission from Resource Mothers, 1993.

RESOURCE INFORMATION

Name of Organization:

Address (if multiple sites, give listing for each):

Telephone: (202)

Contact Person:

Days/Hours of Operation:

Services Offered:

Eligibility Requirements (including which site to go to):

What does applicant need to bring?

Fees:

What public transportation is available?
Metro information (202) 637-7000

Adapted with permission from Resource Mothers, 1993.

PRIDE IN PARENTING
SURVEY OF FAMILY NEEDS

Your Name and your relationship to the child: ______________________

Child's Name: ______________________

Listed below are some of the needs expressed by parents of young children of what they would like help with. Please read each statement. If it is not a need for you at this time, circle number 1. If you are not sure about whether you would like help in this area, circle number 2. If it is a need for you and you would like help at this time, please circle number 3.

	I do not need help	Not Sure	I need help
A. NEEDS FOR INFORMATION			
1. I need more information about my baby's health or development.	1	2	3
2. I need additional training in caring for my baby's health needs.	1	2	3
3. I need more information on the services that are presently available for my baby or older children.	1	2	3
4. I need more information about services that my baby or older children might need in the future.	1	2	3
5. I need assistance in locating/ordering baby supplies.	1	2	3
6. I need a source for formula.	1	2	3
7. I need more information about/or applications for public programs, i.e., WIC, SSI, Housing.	1	2	3
8. I need more information about how children grow and develop.	1	2	3
9. I need more information about how to teach, play, or talk with my child.	1	2	3
10. I need more information about how to handle my baby or older child's behavior.	1	2	3

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	I do not need help	Not Sure	I need help
B. NEEDS FOR THE HOME			
1. I need safety equipment in my home e.g. smoke detector, fire extinguisher.	1	2	3
2. I need a telephone.	1	2	3
3. I need to know who to call in case of an emergency.	1	2	3
4. I need a plan for my children in case I need to leave quickly.	1	2	3
5. I need a plan for child care in case of my own illness.	1	2	3
6. I need assistance with transportation.	1	2	3
7. I need to make changes in my home environment that have not been mentioned. Describe ____________	1	2	3
C. NEEDS FOR SUPPORT			
1. I need to have more time for myself.	1	2	3
2. I need to have more friends.	1	2	3
3. I would like information about a parent support group.	1	2	3
4. I would like to have a referral to talk to a counselor, psychologist, social worker, or psychiatrist about my problems.	1	2	3
5. I would like to talk to a minister who could help me to deal with my problems.	1	2	3
D. NEEDS FOR MEDICAL CARE AND COMMUNITY SERVICES			
1. I need help locating a clinic or doctor for myself or my children for regular medical or dental care.	1	2	3

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	I do not need help	Not Sure	I need help
2. I need specific guidelines for when to call my pediatrician.	1	2	3
3. I need help locating a pharmacist.	1	2	3
4. I need help locating babysitters.	1	2	3
5. I need assistance in locating child care or preschool for my other children.	1	2	3
6. I need help in locating other treatment services for myself or other family member. Describe ____________________	1	2	3
E. **FAMILY ISSUES**			
1. Our family needs help in discussing problems and reaching solutions.	1	2	3
2. Our family needs help in learning how to support each other during difficult times.	1	2	3
3. Our family needs help in deciding who will do household chores, child care, and other family tasks.	1	2	3
F. **FINANCIAL NEEDS**			
1. I need more help in paying for expenses such as food, housing, medical care, clothing, toys, transportation, babysitting, day care or other services.	1	2	3
2. I need information on how to make my budget go further.	1	2	3
3. I or my partner need more training training or help in getting a job or going back to school.	1	2	3

Needs that I'm concerned about which have not been mentioned:

____

____

____

Adapted from: Bailey, D., & Simeonsson, R. (1985). Family Needs Survey. Chapel Hill: Frank Porter Graham Center.

Adapted with permission from Resource Mothers, 1993.

MODEL FOR THE FAMILY INTERVIEW

PHASE OF INTERVIEW	PURPOSE
Introduction A. Explain purpose of the interview. B. Confirm time allotted and format. C. Discuss confidentiality. D. Structure physical environment (if possible). 1. Children 2. Phone calls/TV 3. Sitting arrangement	Reduces parents' anxiety and creates appropriate listening environment.
Inventory A. Opening statement (nonthreatening, open-ended, related to purpose of interview. B. Major portion of the interview–parents do most of the talking	Validates and elaborates information from assessment measures. Identifies additional areas of family needs, strengths, and resources
Summary and Priority A. Summarizing statement B. Exploration of family's priorities	Clarifies consensus and disagreement between parents. Agree on definition of family needs.
Closure A. Recognition of and appreciation for parents' contribution to PSS's understanding of family needs. B. Statement of family and PSS's objectives to be accomplished or worked on by next meeting. C. Opportunity for family to ask any other questions not previously discussed.	Agree upon order in which to consider needs. Focus on objectives or actions to be accomplished by next meeting. Important information may emerge after the "formal" part of the interview is completed.

From Winton and Bayley, 1988.

FAMILY NEEDS PLAN

Family Name: ______________________________
PSS: ______________________________
Date of Plan: ________/________/________
Review Date: ________/________/________

#	What You Need	How To Get It	Who will do it?	When?

Adapted with permission from
Resource Mothers, 1993.

Strategic and reflexive questinos can be used throuth the interview when exploring issues with families, but they particularly lend themselves to goal-setting.

References

Gorden, R. (1969). Interviewing: Strategies, techniques and tactics. Homewood, IL: Dorsey Press.

Ivey, A., (1971). Microcounseling: Innovations in interview training. Springfield, IL: Charles C. Thomas.

Tomm, K. (1987). Intervention interviewing: Part I. Strategizing as a fourth guideline for the therapist. Family Process, 26, 3-13.

Tomm, K. (1987). Intervention interviewing: Part II. Relexive questioning as a means to enable self-healing. Family Process, 26, 167-183.

Winton, P.J., and Bailey, D.B. (in press). The Family-focused intertiew: A collaborative mechanism for family assessment and goal-setting. Journal of the Division for Early Childhood.

TELEPHONE TIPS

- Make a phone list with important telephone numbers and keep it near your phone. Help your client make a phone list of their close family, friends, and the services they will be using.
- Keep extra paper and a pen or pencil near your phone, for writing down information.
- Make a list of the questions you want to ask before you get on the phone.
- Refer to pages ____ for important information in your telephone book. (Show the clients and have them write down which pages those are.)
- Copy the telephone number you wish to call on another paper so that it is easy to see.
- Most large organizations have receptionists who answer the phone. When you reach the agency, ask for the specific department or person with whom you would like to speak.
- Tell them your name and the reason you are calling.
- Speak clearly and use a pleasant tone of voice.
- If someone doesn't understand you the first time, rephrase what you have said.
- Try to be patient. Employees of these organizations aren't always as pleasant and patient as they should be because they may be having problems also. If you are understanding and pleasant, there is a better chance that they will be. Remember, it isn't that they don't like you.
- Try to have a sense of humor.
- Repeat important information to confirm its accuracy, for example, "O.K., So, my appointment is at 4:30 on Wednesday, June 3 at 25th Street and Smith Avenue."
- Ask if there is anything you need to bring and if the services will cost anything, if applicable.
- Thank the person for his/her help.

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DEVELOPING A REFERRAL PLAN

NEEDS FOR INFORMATION

- Want to know more about how smoking in home affects babies.
- Needs to know how to apply for WIC.

NEEDS FOR THE HOME

- Needs a smoke detector.
- Needs a telephone.
- Needs a low cost crib.

NEEDS FOR SUPPORT

- Would like to talk to a minister about her problems.

NEEDS FOR MEDICAL CARE AND COMMUNITY SERVICES

- Needs help in locating a clinic or pediatrician.
- Would like to enroll her 3-year-old in Headstart
- Would like to stop smoking.

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ROLE PLAYS: OBSTACLES TO FOLLOW-UP ON REFERRALS

……

Client #1: Marketa is afraid of going to get Food Stamps because she is not a legal citizen.

Parenting Support Specialist #1: Help find out whether it is necessary to be a citizen to be eligible for food stamps, and if so, what other programs are available. Most programs require social security cards and/or birth certificates. Make sure your client brings whatever identification she has.

……

Client #2: Sharee is reluctant to go to Upper Cardoza Health Center because she doesn't know where it is or how to get there from her house.

Parenting Support Specialist #2: Draw her a map. Help her to find out the exact directions and tell her what bus or buses to take. Also be sure to help her find out what day and hours of the program she should be there. Most programs require social security cards and/or birth certificates. Make sure your client brings whatever identification she has.

……

Client #3: Nolanda is hesitant to seek well-baby care because she doesn't know how much it will cost.

Parenting Support Specialist #3: Help Nolanda call and find out the cost of the services. Help identify what other programs she might be eligible to receive, such as Medicaid, Food Stamps, AFDC, Commodity Foods, etc.

Try not to do the calling, but encourage Nolanda to do it. Also find out the hours of the services and where they are located. Most programs require social security cards and/or birth certificates. Make sure your client brings whatever identification she has.

……

Develop additional scenarios as needed.

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ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

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POST-UNIT EVALUATION

UNIT COVERED: _____

DATE________ ______

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

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5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

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POST-UNIT TEST
UNIT 13

1. Describe 5 social services agencies that the population you will be working with would often need to contact.

    1.

    2.

    3.

    4.

    5

2. How would you help a family identify their needs?

3. What would you do to address those needs?

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Unit 14
MANAGING HOME VISITS

This unit will focus specifically on home visits as our primary intervention. Many skills that will be used for home visits have been taught thus far. This unit will put those skills into the context of home visiting, discuss the general and specific goals of the visits and the ethical considerations involved. Since first visits can set the tone for the future, emphasis will be placed on them.

Objectives

By the end of this session, participants will be able to:

- Define important aspects of home visiting.
- Describe ethical considerations important to home visiting.
- Demonstrate appropriate initiation and termination of a home visit.
- Demonstrate effective communication techniques to be used with clients.
- Describe overall goals of working with families.
- Demonstrate techniques appropriate to crisis situations.

Time

16 hours

Outline

A. Introduction
B. Goals of Working with Families
C. First Home Visit
D. Ethical Considerations
E. Crisis Intervention
F. Summary and Review

Materials

- Resource Mothers. (1993). Handbook (Ch.2 & 18). Sterling, VA: INMED.
- *PIP Training Manual*, Unit 2, "Communication and Relationship Building Skills"
- Bryant, D., Lyons, C., Wasik, B. (YEAR?). Ethical Issues in Home Visiting. Topics in Early Childhood Special Ed., Vol.10,(:4), 92-107.
- Wasik, B.H., Bryant, D.M., Lyons, C.M. (1990). Home Visiting: Procedures for Helping Families. N.Y.: Sage Publications.
- Interpersonal Helping Skills **(Handout #1)**
- Open Ended Questions to Elicit Information on Family Needs **(Handout #2)**
- Important Aspects of Home Visiting **(Training Aid #1)**
- Observation Checklist for Use During Practice Session **(Training Aid #2)**
- Active Listening Techniques **(Handout #3)**
- Scenarios **(Handout #4)**
- Guidelines for Resolving Ethical Issues **(Training Aid #3/Handout #5)**
- Crisis Intervention **(Handout #6)**
- Case Studies **(Training Aid #4)**
- Role Play Feedback **(Overhead #1)**
- Post-Unit Test
- Post-Unit Evaluation
- Blackboard and chalk, or newsprint, markers, flipchart, or tape
- Video equipment: video camera, tripod, tape, VCR, TV

Advance Preparation:

- Read "Ethical Issues Involved in Home Visiting"
- Read *Home Visiting: Procedures for Helping Families*
- Read RM Handbook Chapter 18 and review Chapter 2
- Unit 2 PIP Training Manual as background reading
- Review scenarios in Handout#3. Change, if needed in order to be relevant to your project
- Plan to have community home visitors come and talk about the reality of this type of intervention from a personal perspective.
- Make sufficient copies of handouts.
- Test video equipment, set up camera to videotape role plays.

A. INTRODUCTION (30 minutes)

Rationale: Since many skills have been learned in the training and training is half over, it is now time to put them to use in the context of home visits. This can be both an exciting and scary time for trainees. Increasing knowledge about home visits and practicing important skills can reassure trainees, increase confidence and allay fears. Beginning this unit with reflections and review can bring a new energy to the trainees.

Procedure: 1. Begin this session by reviewing with trainees all that has happened so far in this training. For example, knowledge and skills that have been learned and the growth the group has achieved. Have trainees share their thoughts and feelings at this time.

2. Review objectives for this unit.

3. Ask volunteers to share how they feel about the next part of the training – the actual home visit. Are trainees feeling comfortable with the knowledge gained and skills developed? What questions do they have? Is there apprehension as the training moves into the 2nd half? Encourage group members to answer all questions, all concerns, and provide support for each other. List on newsprint any specific questions or concerns that have not been covered or seem to need review for the group or an individual(s).

B. GOALS FOR WORKING WITH FAMILIES (2 hours)

Rationale: In order to make the home intervention as successful as possible, participants need to have a good working knowledge of what the goals of this type of intervention are.

Procedure: 1. Have Trainees list 5 goals they have for working with families.

- On flip chart list the first 2 from each participant's list, these should include:
  - ⇒ educate
  - ⇒ support
  - ⇒ listen
  - ⇒ empower
  - ⇒ model
  - ⇒ form relationships
  - ⇒ help mom-baby relationship
  - ⇒ encourage
  - ⇒ empathize
  - ⇒ help get services

- How do these relate to goals of:
  - ⇒ being allies and advocates for parent and child vs. allies and advocate for child and adversary of parent
  - ⇒ teaching family vs. being taught by family
  - ⇒ setting goals for families to follow or helping families set and achieve their own goals.

2. Discuss how a home visitor can accomplish these goals: Base discussion on Unit 2 Communication (Handout #6) that includes "Respect, Genuiness, Empathy." Ask trainees what they think communicating these feeling would do for clients? How would they communicate these feelings? Have participants give examples.

3. Review information on Handout #1 "Interpersonal Helping Skills" by first having the participants generate a list for each category on the handout. Make the list on a flipchart or a blackboard. Be sure all the points are covered.

C. FIRST HOME VISIT (3 hours)

Rationale: The first home visit is very important in beginning to establish a relationship with the client but it can be awkward as well. The PSSs need to be comfortable with the goals for this visit and familiar with techniques that can help them proceed smoothly.

Procedure: 1. Discuss the 6 components of the first home visit
   - a) The PSS and client becoming acquainted.
   - b) Reviewing the program purpose and goals as it relates to the mother and baby.
   - c) Defining the PSS's role and that of the client; enlisting client as a partner.
   - d) Clarifying the client's expectations.
   - e) Beginning establishment of rapport.
   - f) Scheduling the next visit.

Overall, the PSSs need to express sincere interest and caring to each family.

2. Distribute Handout #2 "Open Ended Questions to Elicit Information on Family Needs." This information has been introduced in a previous unit (2) of this training program. Review this information and practice asking these questions with one PSS playing the role of the home visitor and one PSS playing the role of the mom.

3. In pairs in front of the group, practice a first home visit scenario starting with the knock on the door. Try different scenarios, for example, a cooperative mother, a withdrawn mother, a hostile mother, an overwhelmed mother, and an eager mother ... Have the group give feedback after each pair has done their role play. As trainer, demonstrate a role play with another trainer if participants are hesitant to begin.

D. ONGOING HOME VISITS (4 hours)

Rationale: Home visiting evolves as more time is spent between PSS and mother and baby. The relationship will depend on the people involved as well as on the skills of the PSS. PSSs need to be aware of the important aspects involved in home visiting and how they will impact their role and that of their clients.

Procedure:

1. Home visitors and clients must learn to know and accept one another, work together to achieve mutually acknowledged goals and then terminate the relationship. Discuss this process of learning, joining and parting.

2. Discuss various aspects of home visiting using Training Aid #1 "Important Aspects of Home Visiting" as a guide. Discuss information and provide specific examples of how these might factor into a home visit.

3. This is a good tome to review helping skills and techniques including observing, listening, and questioning (from Unit 2 PIP Training Manual and Wasik B et. al Home Visiting). Remind trainees that some of this is a review of information from Unit 2. Use Handout #3 "Active Listening Techniques." Review this information and practice the techniques. As trainer, act as client and have participants act as PSS using one of the active listening techniques. If you have a large group, break into smaller groups of 6 to 8 people and have another trainer lead each group. Have "client" describe how it feels when the person they are interacting with is using active listening techniques or if not successfully using these techniques.

4. Review Training Aid #2 "Observation Check List." Use this as a guide when giving feedback.

5. Use Handout #4 "Scenarios" to role play while considering the above techniques. Role play in pairs in front of the group so feedback can be given. If you have a large group of participants, have pairs do role plays and have trainers circulate to give feedback. Have 2 to 3 pairs do role play in front of the group. Give each pair 10 minutes to

prepare their role play. (You can expand this activity by giving pairs "what if" questions.)

E. ETHICAL CONSIDERATIONS (1 hour)

Rationale: There will be many instances in which PSSs will encounter situations that challenge the general strategies used in home visiting. It is therefore very important that they have guidelines as to ethical issues that may arise and how to assess their role in that situation.

Procedure: Using Training Aid #3/Handout #5 "Guidelines for Resolving Ethical Issues," discuss each point and have participants as well as you, as trainer, give real life examples. With each example, play out a scenario as to what could happen in each case; what action would be appropriate and how that might impact the situation.

F. CRISIS INTERVENTION (2 hours)

Rationale: Crises are likely to occur and are unpredictable in nature. The PSS must have some general strategies and guidelines to rely on when faced with a client in crisis.

Procedure:

1. Elicit information on what a crisis is, having trainees share what they consider a crisis.
2. Discuss with participants what has helped them in times of crisis – What they have done for themselves and how others have helped them.
3. Review information on Handout #6 "Crisis Intervention."
4. Develop several short crisis scenarios with the participants. As a whole group or in pairs identify the crisis and brainstorm about an immediate intervention plan.
5. For more practice use Training Aid #4. This will incorporate crisis intervention as well as other issues and strategies learned in this unit.

G. SUMMARY AND REVIEW (30 minutes)

Procedure:

1. Restate objectives in question form. Encourage all trainees to participate.

2. Distribute post-unit evaluation.
3. Distribute post-unit test.

INTERPERSONAL HELPING SKILLS

Helpful Qualities

* Openmindedness/acepting
* Nonjudgemental
* Consistency/dependability
* Confidentiality
* Empathic
* Credibility
* Objective
* Accessible
* Good listener
* Conveys self forgiveness

Why People Do Not Seek Help

* Feelings of failure
* Lack of trust
* Lack of hope
* Fear of being judged

Response Options to Convey Helpfulness

* Non-verbal
  - Eye contact
  - Body posture
  - Minimal encouragement/active iistening
  - Productive silences

* Verbal
  - Reflecting feelings
  - Paraphrasing/summarizing
  - Open versus closed questions

Unhelpful Responses

* Premature reassurance
* Giving advice
* Too personal references
* Over identification
* Judgements

Open-Ended Questions to Elicit Information on Family Needs and Strengths

Questions to Ask:

How are things going with (child's name)?

If more than one adult at visit, ask each one what they think? How they feel?

What kinds of things does (child's name) enjoy doing? What makes him/her happy?

What kinds of things do each of you enjoy doing with (child's name)?

What have you been told about (child's name) (hearing, vision, motor, etc.– using words of family members)?

How does this fit with what you know and believe about (child's name)?

What else do you know about (child's identified disability)?

In what ways has this information been helpful? or not helpful?

What do you think (child's name needs help with, if anything?

What kinds of things have you tried that worked? that didn't work?

What kinds of advice have you been given?

Whose advice has been helpful? not helpful?

What happens in a crisis? *(If crises have been described as happening in the past.)*

What is a typical day like? *(or if family has identified a particular event that they what to focus on, asking what a typical (mealtime, trip to the park, etc.) is like?)*

Can you think of a time that (the event-mealtime, trip to the park, etc.) went well or worked the way you wanted it to? What was happening that made it work?

Who or what was helpful? Who or what was not helpful?

What other things are going on now that are important to you?

ACTIVE LISTENING TECHNIQUES

Type of Statement	Purpose	How Achieved	Examples
A. Encouraging	1. To convey interest 2. To keep person talking	Don't agree or disagree. Use noncommittal words with positive tone of voice.	1. "I see ..." 2. "Uh-huh ..." 3. "That's interesting ..."
B. Restating	1. To show that you are listening and understanding 2. To let person know you grasp the facts	Restate the person's basic ideas, emphasizing the facts	1. "If I understand, your idea is ..." 2. "in other words, this is your decision ..."
C. Reflecting	1. To show that you are listening and understanding 2. To let person know you understand how he/she feels	Reflect the person's basic feelings.	1. "It sounds like you feel that ..." 2. "You were pretty disturbed by this ..."
D. Probing	1. To show that you are listening and understanding 2. To ask for additional facts or opinions 3. To lead the person in a desired direction	Ask the person to provide more details. Perhaps ask if a certain idea follows from what has been said.	1. "How do you think this happened ..." 2. "Could it be that ..."
E. Summarizing	1. To pull important ideas, facts, etc. together 2. To establish a basis for further discussion 3. To review progress	Restate, reflect and summarize major ideas and feelings.	1. "These seem to be the key ideas you have expressed ..." 2. "If I understand you, your overall conclusion about the present situation ..."

Note: This chart represents a summary of the thinking of a number of communication experts regarding "active listening."

Source: Entrepreneurship and Small Business Management. Kenneth R. Van Voorhis, 1980.

SCENARIOS

Have trainees think about the issues they should consider when deciding how to handle these situations. Work in pairs and come up with a plan.

1. You are visiting a client, Tanya, who lives with her mother, older brother and her new baby. While you are discussing ways to keep the baby safe, the baby starts to cry, Tanya's mother makes comments about what you are saying and Tanya gets visibly upset, and her older brother turns on the television in the same room.

2. Your client, Lola, has told you in confidence that she only has enough food for herself and her baby for 2 days. She hopes the food stamps come in time. Lola's boyfriend walks in and goes straight to the refrigerator.

3. On your first visit to Kim and her baby, Kim tells you about the many things she needs help with.

4. Keisha's boyfriend comes to visit while you are there. They start to have a loud, angry argument. To calm things down, Keisha tells him something that you know is not true.

IMPORTANT ASPECTS OF HOME VISITING

- Maintaining Client Focus

- Client Independence

- Honesty

- Confidentiality

- Limits of Intervention

- Termination

Reprinted with permission from Wasik, B.H., Bryant, D.M., Lyons, C.M. (1990). Home Visiting: Procedures for Helping Families. N.Y.: Sage Publications.

OBSERVATION CHECKLIST

For practice sessions and on-the-job supervisory sessions of PSS

ROLES (nonverbal communication skills)

Poor → Good → Outstanding

Check the appropriate box in the space provided	1	2	3	4	5
a. Openness to client/nonjudgmental					
b. Eye contact/appropriate body language					
c. Varies interaction style to meet needs of client					

Comments: ______________________________

____

____

CLEAR (verbal communication skills)

Poor → Good → Outstanding

Check the appropriate box in the space provided	1	2	3	4	5
a. Clarifies					
b. Listens					
c. Encourages/gives praise					
d. Acknowledges (what a client says, is feeling, etc.)					
e. Reflects and repeats back					

Comments: ______________________________

____

____

____

HOME VISITING SKILLS

Poor → Good → Outstanding

Check the appropriate box in the space provided	1	2	3	4	5
a. Establish rapport with client					
b. Asks open-ended questions and follows when needed with probing questions					
c. Clearly presents agenda for visit; considers client's needs					
d. Provides accurate information on the topic being discussed; reviews appropriately					
e. Is organized with materials for visit					
f. Uses appropriate support materials: * with mothers and other adults * with babies					
g. Clearly models skills/behaviors important to lesson; has mother demonstrate					
h. Interacts appropriately with baby					
i. Summarizes and leaves plan					
j. Schedules next appointment					

Comments: ______________________________

____

____

____

____

____

HOME ENVIRONMENT OBSERVATIONS

	Adequate	**Inadequate**
Temperature		
Floors		
Windows		
Doors		
Sockets		
Ceiling		
Toys		
Reading material		
TV (on/off)		
Radio (on/off)		
Clock		
Mirrors		
Number of people present		

Comments: ______________________________

BEST COPY AVAILABLE

GUIDELINES FOR RESOLVING ETHICAL ISSUES

(Reamer 1982)

1. Rules against basic harms to life's necessities (such as life, health, food, shelter, mental health) overrides rules against harms such as lying, revealing confidential information, or threats to such things as recreation, education, wealth.

2. An individual's right to basic well-being (life's necessities) overrides another individual's right to freedom.

3. An individual's right to freedom (to make decisions and choices) overrides his or her own right to basic well being.

4. Obeying laws, rules and regulations overrides an individual's right to act freely if that action conflicts with the laws, rules and regulations.

5. Individual's rights to well-being may override laws, rules and regulations in cases of conflict.

6. The obligation to prevent such basic harms as starvation and to promote public good such as housing, education, and public assistance overrides the right to keep property.

Repri[illegible] with permission from Wasik, B.H., Bryant, D.M., Lyons, C.M. (1990). Home Visiting: Procedures for Helping Families. N.Y.: Sage ublications.

CRISIS INTERVENTION

Important Reminders:

⇒ Calmness breeds calmness.

⇒ To intervene appropriately, one must be able to tune into what the family is experiencing but remain calm and objective in order to help.

⇒ To intervene effectively, one must be able to tolerate another person's mood state – even when that mood state involves panic and pain. Some of the feelings experienced during a crisis are confusion, chaos, out of control, foggy mind-set, fear. These can create additional feelings of hopelessness and isolation. The person in crisis may experience sleeplessness, diet changes, increased irritability.

PRINCIPLES OF CRISIS INTERVENTION

⇒ Help the person(s) identify the problem in reality; try to correct obvious distortions.

⇒ Help the person(s) identify their situational (people) supports and support them in contacting those supports.

⇒ Help the person(s) identify usual coping mechanisms and support them in utilizing those coping mechanism; using coping strategies in the short run is what is needed now, but often they would not be healthy long term behaviors.

⇒ Help the person(s) plan for the immediate future–the next one or two steps. Be clear on what you can and cannot do, but since you were with this person at the crisis time, do follow-up soon with contact.

NOTE: Time for emotional recovery is needed from crises otherwise the person may overreact the next time. People can only survive in crisis mode for a short period of time before it has more damaging results. Check how family is viewing their situation over time.

CASE STUDIES

Note: Please adapt these case studies to be sure your practice session reflects the special cultural and social needs of your community. These case studies will be used for practicing using information about and techniques for home visiting.

……

Keisha Thomas is 19 years old and lives with her grandmother, her mother, a fourteen-year-old sister, a seventeen-year-old brother and her 6-month-old daughter, Tamieka. Keisha has never known her father. The family lives in a three room, fifth floor apartment. Keisha works part time. Her mother works as a teacher's assistant, her grandmother stays home, but is very active in the Missionary Society at the local church. Keisha is very much in love with her boyfriend, but her grandmother and mother do not want her to see him.

……

Rochelle Washington is 21 years old. She and her boyfriend, George, live with his mother in a one bedroom apartment. George is 20 years old and is unemployed, but actively looking for work. George's mother is disabled and unable to work. Rochelle wants to go to a job training program. She has a newborn baby. Rochelle has been advised to sign up for Medicaid and WIC.

……

Amy Parker is 20 years old and has been living with Jim for two years. She also lives with her two-year-old son, Jackson, and infant daughter Sara. Jim has been having an increasing problem with alcohol and has had some loud arguments with Amy. She is afraid her husband will beat her.

……

Beverly Jones is 18-years-old. Her parents kicked her out of the house when she told them she was pregnant. The baby is now 3 weeks old. Beverly has been staying with friends and going to school during the day when her friends can watch the baby. She has not taken the baby to the health clinic and does not always have enough food for herself or the baby.

……

Donna Jackson is 19 years old. Donna has had a long history of alcohol and other drug use, but claims she isn't using right now. Donna has been living with friends and various relatives for the past ten years, after her parent's divorce. Her father is an alcoholic and used to beat her and her mother. Donna does not know who the father of her baby is, she delivered 2 weeks ago.

POST-UNIT EVALUATION

UNIT COVERED: _______

DATE _______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _______ If not, please explain.

Adapted with permission from Resource Mothers, 1993.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

Adapted with permission from Resource Mothers, 1993.

POST UNIT TEST
UNIT 14

1. List 3 overall goals of working with families.

2. How could you begin to work towards these goals? Describe 3 ways.

3. List 3 goals for the first home visit.

4. How would you begin your first home visit with a mom?

5. Name 3 components of home visiting of which you must be aware. Explain why?

6. Describe an ethical issue that you might confront while home visiting. What would you do?

8. What is one important technique you could use to help a mom in crisis?

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

Adapted with permission from
Resource Mothers, 1993.

Unit 15

CHILD GROWTH AND DEVELOPMENT: BIRTH TO ONE MONTH

In this unit, participants will review developmental milestones of infancy, from birth to one month, learn how to help parents understand this stage of development and interpret infant behavior, share activities that both parents and their babies will enjoy, recognize possible problems in infant growth and development and identify available resources for babies and parenting families.

Objectives

By the end of this unit, participants will be able to:

- Describe changes in the infant's physical appearance during the birth to one month period.
- Describe infant development during the birth to one month period.
- Discuss how parents and caregivers can help infants develop optimally during this stage.
- Describe how the developmental changes in this period affect parenting approaches.
- Demonstrate how to talk to mothers about ways to play and interact with their infants during this stage.
- Demonstrate an understanding of the continuity of development, of how developmental milestones at this stage relate to those in the stages after this one.
- List three possible developmental problems to which Parenting Support Specialists should be alert during this stage.
- Describe developmentally appropriate play and interaction with an infant at this stage of development.

Time

10 hours

Outline

A. Developmental Milestones
B. Site Visit
C. Providing Guidance and Support
D. Summary and Review

Materials

- Resource Mothers. (1993). Resource Mothers Handbook (Ch. 14). Sterling, VA: INMED.
- Resource Mothers. (1993). Resource Mothers Curriculum Sourcebook (Ch. 12). Sterling, VA: INMED.
- Shelov, S.P. & Hanneman, R.E. (Eds.) (1991). The American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age Five, (pp.133-164). N.Y.: Bantam Books.
- Video: "Infants and Their Families, March of Dimes."1275 Mamaroneck Ave., White Plains, NY 10605, (914) 428-7100.
- Weitzberg, B. (1992). Exploring the World of Infants and Toddlers: A Training Manual about Infants, Toddlers, and Their Parents. Baltimore, MD: Friends of the Family, Inc.
- Changes in Appearance: Birth to One Month **(Handout #1)**
- What a Newborn Looks Like **(Handout #2)**
- Developmental Milestones **(Handout #3)**
- States of Consciousness **(Handout #4)**
- Newborn Reflexes **(Handout #5)**
- Developmental Health Watch **(Handout #6)**

- Site Visit Observation **(Handout #7)**
- Safety Check **(Handout #8)**
- Role Play Feedback **(Overhead #1)**
- Scenarios **(Training Aid #1)**
- Life size doll
- Post-Unit Evaluation
- Post-Unit Test
- Blackboard and chalk or newsprint, markers and tape.
- Video equipment: camera, tripod, tape, VCR, TV

Advance Preparation:

- Review Chapter 14, "Child Growth and Development" of the *Resource Mothers Handbook* and ask trainees to review it ahead of time.

- Review *Resource Mothers Curriculum Sourcebook*, Unit 12, Child Growth and Development.

- Review *Caring for Your Baby and Young Child*, pp. 133-164.

- Review *Exploring the World of Infants and Toddlers*, pp. 5-29

- Review video: Infants and Their Families.

- Arrange for a demonstration of infant behavior and development by inviting one or two mothers with infants this age, who would be willing to let their babies be observed.

- If you are affiliated with a hospital, arrange for a neonatologist to describe an infant's appearance and behavior with a real baby.

- Make sufficient copies of any handouts to be used.

- Bring a copy of S.P. Shelov and R.E. Hannemann's American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5, and other books on child development.

- Test video equipment and set up camera to record role plays.

A. DEVELOPMENTAL MILESTONES (3.5 hours)

Rationale: In the beginning, it may seem like all a newborn baby does is sleep, eat, cry and mess his diapers. By the end of the first month, he will be much more alert and responsive. Gradually he'll begin moving his body more smoothly and with much greater coordination--especially in getting his hand to his mouth. He will listen when someone speaks to him, watch when someone holds him, and occasionally move his own body to respond to his mother or to attract her attention. But before we look at the baby's increasing capabilities, let's look at the changes in physical appearance that take place during the first month. (Shelov, 1991, p. 133)

1. APPEARANCE

Rationale: Mothers will notice changes in their baby's physical appearance during the early weeks of life. The Parenting Support Specialist can ease mothers' concerns by explaining the typical changes that occur.

Procedure: a. **Mini-lecture**. If you are affiliated with a hospital, arrange for a neonatologist to review this information on a real baby. If you cannot do this, use a doll to review the appearance of the newborn and changes during the first month (Shelov 134-135).

b. **Pencil-and-Paper Review**. Give the trainees the **Changes in Appearance: Birth to One Month** Worksheet (**Handout #1**). Ask them to jot down one or two words in as many categories as they can to describe the changes. While participants are working, write the categories on the blackboard or newsprint. Use **Handout #2, What a Healthy Newborn Looks Like**, as a guide.

Process the participant's responses by asking trainees to tell you the changes they remembered. Write these in each category. Discuss the changes and answer any questions. At the end of the discussion, distribute **Handout #2, What A Healthy Baby Looks Like**. Review to see if all the comments of the participants were included.

2. SKILL AREAS

Rationale: Understanding normal growth and development will help Parenting Support Specialists interpret the baby's behavior to parents.

Procedure: a. **Demonstration of skills of one month infant.** Participants will get more out of this session if they can actually observe babies performing the behaviors being discussed rather than relying on only written or verbal descriptions. Illustrate the baby's skills by (1) asking mothers with infants to demonstrate the various milestones, (2) demonstrating the baby's competencies through the Brazelton Neonatal Behavioral Assessment Scale, and/or (3) showing the video, Infants and Their Families.

b. **Review developmental skills.** Present the information in **Caring for Your Baby and Young Child**, pp. 141-148. Use **Handout #3, Development Milestones** as another guide (or a similar book on development). Include reflexes, states, colic, first smile, movement, vision, hearing, smell and touch, and temperament. Use **Handout #4, States of Consciousness and Handout #5, Newborn Reflexes**.

3. DEVELOPMENTAL ALERTS (1 hour)

Rationale: Since PSSs will be seeing the mothers and babies weekly, their knowledge of developmental alerts can help them identify potential problems and result in needed intervention.

Procedure: a. **Developmental Health Watch Chart. Handout #6, Developmental Health** based on the one in **Caring for Your Baby and Young Child**, p.147. Add any "Red Flag" behaviors you think are important or that participants suggest should be added. Write participants suggestions on the blackboard and instruct participants to add them to their copy of the Developmental Health Watch Chart.

B. SITE VISIT (3 hours)

Rationale: Observing infants & caregivers at this stage will make the information more meaningful to PSSs.

Procedure: Participants will observe an individual infant and mother or caregiver in a day care center or home, in a private home, or at one of the hospital sites and will complete a structured observation following the format for Pride in Parenting Training Site Visit Observation, **Handout #7**.

After site visit, discuss with the whole group what PSSs observed.

C. PROVIDING GUIDANCE AND SUPPORT (2.5 hours)

Rationale: Practice can help PSSs to integrate skills and build confidence.

Procedure: **Role Plays**. Divide group into pairs and give each questions that a mother might ask about her infant, birth to one month. Use **Training Aid #1, Scenarios**. After the pairs have had a chance to discuss their question and refer to their written materials, have one of the pair ask the question before the whole group and the other respond with developmental information appropriate for the age.

Give special attention to phrasing and general approach which reflects respect and caring for the mother.

Following each role play, process the activity by asking first the participants doing the role play, then the rest of the participants, the questions on **Overhead #1, Role Play Feedback**.

You may repeat the role plays with the partners switching roles if there is enough time. (Note: make written notes about each trainees performance as part of the Trainee Evaluation.)

2. **Safety Check Chart**. Give each participant a copy of the Safety Check on page 164 of **Caring For Your Baby and Young Child (Handout #8).** Discuss each of the items tying in the developmental capacities of the infant.

D. SUMMARY AND REVIEW

Procedure: 1. Rephrase the objectives on the first page of this unit as questions. Ask a volunteer to answer each question.

2. Distribute the post-unit evaluation forms

3. Distribute post-unit test.

CHANGES IN APPEARANCE: BIRTH TO ONE MONTH

Growth

Arms and Legs

Head

Skin

Temperature Control

Umbilical Cord

WHAT A HEALTHY NEWBORN LOOKS LIKE

Skull: The top of a newborn baby's skull has two soft spots. You can see these spots. One is at the lower center of the forehead, above the eyebrows. The other is near the very top of the head. You will not hurt your baby if you touch these spots.

Eyes: A newborn baby's eyes are light in color. They may look crossed. Or they might seem to stare. This is because newborn babies can't focus their eyes. When your new baby cries, you won't see any tears. It takes time for the tear ducts to start to work.

Hands: A newborn baby's hands usually are in a tight fist. If you open your baby's hands, you'll see fine lines on the palms. The fingernails will be very thin.

Genitals: The sex organs of a newborn usually look big compared to the small size of the baby's body. This is true for both girls and boys.

Feet: A newborn baby's foot is not complete at birth. The heel bones are formed, but the other bones will not form until later.

Head: A newborn baby's head usually looks very large. While a baby is being born, there is a lot of pressure on the head. The soft spots allow the head bones to get pushed together when the baby is born. This might cause the head to have a funny shape. It will look better after a while. Your baby may have lots of thick hair or he may have no hair at all.

Face: Most newborn babies have fat cheeks, a tiny nose and hardly any chin. The face may look swollen. The eyelids may be puffy.

Body: A new born baby's body usually has a short neck, tiny shoulders, swollen breasts, a fat belly and thin hips. You'll also see the "umbilical stump". It will become the belly button.

Legs: A newborn baby's legs usually are pulled up against the belly. This is the way they are when the baby is in the womb. The knees usually are slightly bent. They turn toward the outside.

Skin: A newborn baby's skin is usually dry and thin. You should be able to see many fine red lines on it. These are veins. Light-skinned babies usually look rosy red. Most black babies look light at birth. Later they get darker in color.

DEVELOPMENTAL MILESTONES

Birth to One Month

Movement
- Head turns side to side
- Lifts head momentarily
- Head flops backward if unsupported
- Waves hands and kicks feet when lying on back
- Movements may be jerky
- Explores hands in mouth and together

Vision
- Focuses 8 to 12 inches away
- Looks at objects or people
- Eyes wander and occasionally cross

Hearing and Making Sounds
- Startled in response to loud sounds
- May turn toward a familiar sound or voice
- Cries, coos and makes movements

Emotional and Social Development
- Quiets when picked up
- Likes to be picked up and held
- Cries and knows someone will come

STATES OF CONSCIOUSNESS

Researchers have noted different states of consciousness in newborns. They are:

- **DEEP SLEEP STATE**
- **LIGHT SLEEP STATE**
- **DROWSY STATE**
- **QUIET-ALERT STATE**
- **ACTIVE ALERT STATE**
- **CRYING**

DEEP SLEEP – Identified by inactivity and closed, unmoving eyes with regular breathing and pale skin.

LIGHT SLEEP – Identified by irregular breathing, flushed skin, and closed, but moving, eyes. Babies move during light sleep.

DROWSY STATE – Characterized by increased motor activity, startle behavior, and fluttering eye movements. The state that babies enter as they move from a sleep state to an awake state.

QUIET-ALERT STATE – Infant's eyes are open, bright, and alert. Infants look at their surroundings. Very little movement is observed.

ACTIVE ALERT STATE – Identified by random spurts of movements. Infant's eyes are not as bright or focused as in the quiet-alert state. Infants may be fussy.

CRYING – Characterized by flushed skin, vigorous activity, and crying.

Recognition of these states has enabled researchers to learn a tremendous amount about infants in the past few years. On average, newborns lie quietly awake for one hour of the day – usually for five to ten minute intervals around feedings. It is only during these short, quiet-alert states that infants appear to perceive the world with all of their senses.

Reprinted with permission from: Wietzberg, B. (1992). *Exploring the World of Infants and Toddlers*, Baltimore, Maryland: Friends of the Family, Inc., p.10.

NEWBORN REFLEXES

- **MORO REFLEX OR STARTLE REFLEX** — When newborns are startled by a sudden change in position or noise, they startle, fling out their arms and legs, with fingers spread wide, and then draw their arms and legs back toward their bodies in a clasping motion.
- **PALMAR GRASP REFLEX** — When newborn's palms are stroked, they will close on the object and grasp it.
- **TONIC NECK REFLEX (FENCER POSITION)** — When newborn's heads are turned to one side, their whole body arches away from the side they are turned to. The arm on that side extends and the opposite arm flexes, giving them the look of a fencer.
- **ROOTING and SUCKING** — When the cheeks of newborns are touched, they turn toward the direction of the stroking object and the sucking reflex follows. When the insides of their mouths are touched, they start to suck.

Newborns have many other reflexes: a stepping reflex, a hand-to-mouth reflex, a swimming reflex, and more.

Reprinted with permission from: Wietzberg, B. (1992). *Exploring the World of Infants and Toddlers*, Baltimore, Maryland: Friends of the Family, Inc., p.13.

DEVELOPMENTAL HEALTH WATCH

If, during the second, third, or fourth weeks of your baby's life, he shows any signs of developmental delay, notify your pediatrician.

- **Sucks poorly and feeds slowly**
- **Doesn't blink when shown a bright light**
- **Doesn't focus and follow a nearby object moving side to side**
- **Rarely moves arms and legs; seems stiff**
- **Seems excessively loose in the limbs, or floppy**
- **Lower jaw trembles constantly, even when not crying or excited**
- **Doesn't respond to loud sounds**

Reprinted with permission from: Shelov, S.P. & Hannemann, R.E. (1991). *Caring For Your Baby and Child*: Birth to Age Five. New York: Bantam Books. p. 147.

PIP TRAINING

SITE VISIT OBSERVATION

Name of Setting:

Age of Child Observing:

Number of Children:

Number of Adults:

1. Observe the environment carefully; look at facilities, materials and personnel. In what way(s) is it appropriate for:
   a. Children's play and interaction:
   b. Daily caretaking:
   c. Safety:

Is it inappropriate in any way?

   a. Children's play and interaction:
   b. Daily caretaking:
   c. Safety:

2. Describe the personality or interaction style of the baby you observe.

3. What do the caregivers do to encourage the baby's development?

4. For the specific baby you observe, what skills do you see s/he has?

   a. Motor:

   b. Cognitive:

   c. Emotional:

   d. Social:

   e. Communication:

5. Do you notice that the child has preferences?

	What the Child Prefers	**How Do You Know**
For Toys or People?		
For Specific Toys?		

6. Do you have any concerns about the baby? What are they? Why are you concerned?

SAFETY CHECK

Car Seats

- Your baby should ride in a properly installed, federally approved car seat *every time* he is in the car. At this age, he should ride in the rear-facing position. Children should always be in the back seat of any vehicle.

Bathing

- When bathing the baby in the sink, seat him on a washcloth to prevent slipping, and hold him under the arms.

- Adjust the temperature of your water heater to less than 120 degrees so the hot water can't scald him.

Changing Table

- Never leave your baby unattended on any surface above the floor. Even at this young age, he can suddenly extend his body and flip over the edge.

Suffocation Prevention

- If you use baby powder, shake it out away from your infant's face so he doesn't inhale it.

- Keep the crib free of all small objects (safety pins, small parts of toys, etc.) that he could swallow.

- Never leave plastic bags or wrappings where your baby can reach them.

Fire Prevention

- Dress your baby in clothing treated with flame-retardant chemicals.

- Install smoke detectors in the proper places throughout your home.

Supervision

- Never leave your baby alone in the house, yard, or car.

Necklaces and Cords

- Don't attach pacifiers, medallions, or other objects to the crib or body with a cord.

- Don't place a string or necklace around the baby's neck.

Jiggling

- Be careful not to jiggle or shake the baby's head too vigorously.

- Always support the baby's head and neck when moving his body.

Source: Shelov, S.P. & Hannemann, R.E. (1991). Caring for Your Baby and Young Child: Birth to Age 5. New York: Bantam Books, p. 164.

SCENARIOS

ROLE PLAY - Growth and Development: Birth to One Month

My baby does not sleep much during the day, but he is fairly content. But around dinner time, he starts to cry. He will cry for 2 or 3 hours and nothing I can do helps. Sometimes I feel like just leaving him in the apartment and getting out of there. What can I do?

ROLE PLAY - Growth and Development: Birth to One Month

When I hold my baby, his head flops backward. I think he should be able to hold it up by now, so I try to make him do it. Do you think something is wrong with him?

ROLE PLAY - Growth and Development: Birth to One Month

My baby sleeps in a crib in my room. He wakes up lots of times during the night and makes little whimpering sounds. I pick him up to see what is the matter and sometimes change his diaper or feed him. It is then really hard to get him to go back to sleep. What should I do?

ROLE PLAY - Growth and Development: Birth to One Month

I can't get my baby to nurse. She starts out sucking well and seems to be hungry and wants milk. But after a short time, she starts to look around at what is going on the room and stops and starts sucking for short periods. She then gets really frantic. She seems hungry, but can't suck long enough to get enough milk. What should I do?

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

UNIT TEST
Child Growth and Development: Birth to One Month

1. List three changes in the infant's physical appearance during birth to one month that might be of concern to a mother.

____
____
____

2. How would you describe the infant's development during the birth to one month period to the mother and family? Give a short phrase or sentence description in each of these developmental areas:

Motor: ______________________________________

Cognitive: ___________________________________

Emotional: ___________________________________

Social: ______________________________________

Communication: _______________________________

3. What safety tip will you be sure to give mothers during this period?

____
____
____

4. List three possible developmental problems to which Parenting Support Specialists should be alert during the birth to one month stage.

____
____
____
____

POST-UNIT EVALUATION

UNIT COVERED: _____

DATE _______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

Unit 16
CHILD GROWTH AND DEVELOPMENT: ONE TO FOUR MONTHS

In this unit, participants will review developmental milestones of 1-4 months, learn how to help parents understand stages of development and interpret infant behavior, share activities that both parents and their babies will enjoy, recognize possible problems in infant growth and development and identify available resources for babies and parenting families.

Objectives

By the end of this unit, participants will be able to:

- List the major developmental milestones during the one to four month period.
- Discuss how parents and caregivers can help infants develop optimally during this stage.
- Describe three ways mothers can help their baby's development during this period.
- Describe how the developmental milestones in this period require changes in parenting approaches.
- Demonstrate how to talk to mothers about ways to play and interact with their infants during this stage.
- Demonstrate an understanding of the continuity of development, of how developmental milestones at this stage relate to those in the stages before and after this stage.
- List three possible developmental problems to which Parenting Support Specialists should be alert during this stage.
- Demonstrate developmentally appropriate play and interaction with an infant at this stage of development.

Time

23 hours

Outline

A. Developmental Milestones
B. Site Visit
C. Providing Guidance and Support
D. Summary and Review

Materials

- Resource Mothers. (1993). Resource Mothers Handbook (Ch. 14). Sterling, VA: INMED.
- Resource Mothers . (1993). Resource Mothers Curriculum Sourcebook (Ch. 12). Sterling, VA: INMED.
- Weitzberg, B. (1992). Exploring the World of Infants and Toddlers: A Training Manual about Infants, Toddlers and their Parents. Baltimore, MD: Friends of the Family, Inc.
- Shelov, S.P. & Hanneman, R.E. (1991). American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5, (pp. 165-187). N.Y.: Bantam Books.
- Video: *Your Baby and You: Understanding Your Baby's Behaviors*. Communications Skills Builders, 3830 E. Bellevue, P.O. Box 42050, Tucson, AZ 85733.
- Brazelton, T.B. (1993). Touchpoints. Your Child's Emotional and Behavioral Development. Redding, MA: Addison-Wesley.

- Growth Charts
- Developmental Milestones/Skills on index cards **(Handout #1)**
- Developmental Alerts **(Handout #2)**
- Developmental Health Watch **(Handout #3)**
- Safety Check and Immunization Alert **(Handout #4)**
- Helping Parents to Be Parents **(Handout #5)**
- Working with Parents **(Handout #6)**
- Site Visit Observation Form **Handout #7)**
- Child Development Scenarios **(Handout #8)**
- Evaluation of Teaching Materials **(Overhead #1)**
- Role Play Feedback **(Overhead #2)**
- Post-Unit Evaluation
- Post-Unit Test
- Blackboard and chalk or newsprint, markers and tape
- Video equipment: cameras, tripod, tape, VCR, TV

Advance Preparation:

- Review Chapter 14, "Child Growth and Development" of the *Resource Mothers Handbook* and ask trainees to review it ahead of time.
- Review *Resource Mothers Curriculum Sourcebook*, Unit 12, Child Growth and Development.
- Review *Exploring the World of Infants and Toddlers*, pps. 39-41, 43-44, 46-65, 128.
- Review *Caring for Your Baby and Young Child*, pp. 165-187.
- Review *Touchpoints*.
- Review video: *Your Baby and You: Understanding Your Baby's Behavior*.
- Arrange for a demonstration of infant developmental milestones by inviting to the training session two or three mothers with infants of this age, who would be willing to let their babies demonstrate various milestones.
- Write developmental milestones/skills on index cards.
- Obtain copies of infant growth charts from a pediatrician or other health care provider.
- Make sufficient copies of any handout to be used.
- Make copies of overheads to be used.
- Bring a copy of S.P. Shelov and R.E. Hanneman's *American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5*, and other books on child development.
- Bring books, curriculum guides, kits and other materials available to Parenting Support Specialists to use with mothers and babies.
- Test video equipment, set up camera to record role plays.

A. INTRODUCTION (1-3/4 hours)

Rationale: It is important for the PSSs to have a clear understanding of what successful parenting is about in order to support and encourage this. As a beginning to the next step of growth and development, some factors related to positive parenting will be discussed.

Procedure:

1. Review the following descriptors involved in successful parenting:
   - the parent takes joy and pride in the infant's developing abilities
   - the infant feels secure and special
   - the parent provides a safe, structured environment
   - the parent has self-confidence and flexibility to respond to individual needs and differences in her children and to change her ways as they grow and change.

Ask the participants for examples from their own experiences that may have led to these feelings/situations.

2. Discuss how, as PSSs, they can facilitate this positive parenting. Have the participants share thoughts on how each of the above situations can be encouraged.

Possible responses:
- observing and acknowledging baby's growth
- modeling positive parenting
- using active listening/reflecting with respect & empathy/positive reinforcement
- providing opportunities for success in parenting and thus an opportunity to give positive reinforcement.

To introduce another strategy in positive parenting, have the group discuss:
- traditions and events in their own families that made them feel special, or
- things they do with their own children so that the children feel valued and special.

Discuss how they can encourage families to do this. Ask what they do or did as children.

Possible responses:

- share own experiences
- help family plan what they would like to see as traditions in their nuclear family.

B. DEVELOPMENTAL MILESTONES (7 hours)

Rationale: Give the Parenting Support Specialists a framework into which to fit the detailed information which is to follow by introducing the 1 to 4 month old baby based on information in **Caring for Your Baby and Young Child**, pp. 165-187. Be sure to include these points:

- routine schedule of feeding and eating
- beginning to understand and adjust to having a new baby
- change from totally dependent new born to baby developing more voluntary control
- active, responsive baby
- more social, more sound play
- an apparent step backward may mean a major developmental leap forward is coming ("touchpoints")

1. APPEARANCE

Rationale: Mothers will continue to notice changes in their baby's physical appearance during these early months. Parenting Support Specialists can help mothers know what to expect.

Procedure: **Mini-lecture**. Babies should continue to grow at the same rate established during the first few weeks of life. On the average, they:

- gain 1 ½ to 2 pounds each month
- grow 1 to 1 ½ inches each month
- increase diameter of head by ½ inch each month

Review growth charts and graph the growth of 2 different babies

Head: The soft spot on the baby's head should be soft and flat at two months. By four months, the soft spot at the back should be closed. The head may look big and out of proportion because it is growing faster than the rest of his body. Do not worry about this. It is normal. His body will catch up over time.

Body: At two months, he will look round and chubby. He will begin to loose some of his fat as he moves his arms and legs and begins to develop muscles. His arms and legs begin to "loosen up" and seem to stretch out. This will make him look taller and thinner.

2. SKILL AREAS

Rationale: Understanding normal growth and development will help PSS's interpret the baby's behavior to parents.

Procedure: a. **Mini-lecture and demonstration.** Show a typical 1-4 month old baby using the video, "Your Baby and You: Understanding Your Baby's Behavior". Review the developmental milestones presented in **Caring for Your Baby and Child**, pp. 167-179. Give each participant a copy of the *Developmental Milestones*, **Handout #1**. Write the categories on a flip chart and tape this paper to the wall in the front of the room.

b. **Live demonstration.** Invite two or three mothers to play with their babies before the group. After a few minutes, ask the trainees what skills they observe. Process their responses by writing them on the flip chart. Next ask trainees to tell which developmental area (movement, vision, hearing and making sounds, and emotional and social development) each skill represents. Write the name of the area after each skill. Participants may discover that some observed skills can represent more than one area. Stress the inter-relatedness of skills at the 1 to 4 month age.

c. **Activity: Elicitation of skills.** Write the following developmental milestones/skills on index cards:

- Pushes up on hands and arms when lying on stomach
- Opens and shuts hands
- Swipes at dangling object
- Grasps and shakes rattle
- Visually follows moving object
- Turns head toward direction of sound when on back
- Makes sound in response to voice

Have trainees draw one card. Ask them to demonstrate that skill with one of the babies. Facilitate the demonstration by giving suggestions as necessary. Have appropriate materials available.

3. DEVELOPMENTAL ALERTS

Rationale: Since PSS's will be seeing mothers and babies weekly, their knowledge of developmental alerts can help them identify potential problems that may result in needed intervention.

Procedure: a. **Discussion.** Remind participants that each baby is an individual and will develop at his own rate. However, there may be times when the Parent Support Specialist is concerned about a baby during this time of 1 to 4 months. Ask participants to tell you what they would consider warning signs for medical or developmental problems during this period. Process their answers by writing them on the flip chart.

b. **Activity.** Give each participant a copy of the *Developmental Alerts Handout from* Resource Mothers Unit 12, **Handout #2,** and the *Developmental Health Watch,* **Handout #3**, from p. 180 of **Caring for Your Baby and Child**. Ask them to incorporate the Alerts from Resource Mothers into the longer Developmental Health Watch List, then match any warning signs that were listed by the trainees to the ones included on the charts.

Discuss each alert thoroughly, making sure everyone understands. Answer any questions they have about what is normal or typical development and when they should be concerned.

Give each participant "Safety Check" and "Immunization Alert" **(Handout #4)**. Review each point carefully.

C. SITE VISIT (7 hours)

Rationale: Observing infants and caregivers at this stage will make the information more meaningful to PSSs.

Procedure: 1. Trainees will visit an infant care or early intervention site to observe infants one to four months of age to complete a structured observation following the format for Pride in Parenting Training Site Visit Protocol, **Handout #7**.

2. After the site visit, in the whole group, discuss what PSSs observed.

Ask each trainee to discuss the ways babies played and interacted with their parents/caregivers. What milestones did they observe? How did parents/caregivers facilitate development?

D. PROVIDING GUIDANCE AND SUPPORT (7 hours)

Rationale: In this part of the training, participants will examine ways to interact with parents around child development issues. As pointed out in the PSS's training, it is important for Parent Support Specialists to learn how to support and encourage without undermining the self-esteem of the parents.

Procedure: 1. **Group Discussion.** Remind the group of the exercises they practiced in Unit 2 on using praise and encouragement. Parenting is a difficult and sometimes unrewarding job. It is an area where PSS's need to give lots of praise and encouragement. Everyone needs to feel they are valued and cared for, and that is particularly true of new parents. PSS's can help to build their clients' self-esteem by acknowledging and commending them for positive attempts at parenting, like keeping their infants clean, talking and playing with them, etc. Remind the trainees that encouragement of any positive and nurturing behavior will serve to empower their clients.

2. **Ask participants** to name some benefits of providing positive rather than negative feedback when talking with parents. **Possible responses** might be:

- Positive feedback helps build self-esteem
- It helps people feel better about themselves
- They perform better
- They treat other people better

3. **Distribute Handout #5,** Helping Parents to be Parents. Go around the room and have the PSS's take turns reading paragraphs. After each section is read, discuss it. For example, in the first section, make sure everyone understands what is meant by an "indirect comment." What additional examples can trainees give?

Continue in this fashion, asking your own questions at the end of each section to make sure all the messages are understood. Then ask trainees to think up additional statements that exemplify each of the guidelines. Distribute **Handout #6**, Working with Parents. Ask participants if they agree with each statement, what is their role in each instance.

4. **Evaluation of teaching materials.** Distribute any books, curriculum guides, kits and other materials available to Parenting Support Specialists to use with mothers and babies. Ask participants to review the materials focusing specifically on activities for infants one to four months. Allow participants fifteen minutes to review the materials. ASK: Were the materials easy to understand? Which ones did you like best and why? **(Overhead #1)**.

5. **Mini-discussion**. Sometimes parents have a hard time knowing how to play with their babies. This is especially true for young parents and parents who are isolated from family and friends. It is also difficult for parents to think of playing with a baby who is so young (1 to 4 months).

Ask who knows ways to play and have fun with a young baby. Let participants share their ideas with one another. Make several suggestions and show where these techniques are presented in the curricular materials previously reviewed.

6. **Activity: Role Play Scenarios**. Ask each participant to select a partner or assign partners. One will play the Parenting Support Specialist and the other the mother. Then they will change:

Take slips of folded paper with child development role play scenarios which have been written prior to training **(Handout #8)**. Place them in a container and ask each "mother" to pick one child development scenario.

Give each team 15 minutes to jot down responses to the question asked at the end of the scenario. They may use the books and materials just reviewed. Ask them to incorporate suggestions from **Handout #5**, Helping Parents to be Parents. Then let them take turns practicing things the Parenting Support Specialists can say and do.

Bring everyone back together and ask each team to play out its scenario with the mother introducing the scenario to the Parenting Support Specialist. The PSS should talk to and demonstrate to the mother as she would on a home visit. Following each scenario, process the activity by asking first the participants doing the role play, then the rest of the participants the questions in **Overhead #1**. Write the questions, but not the answers, on the flip chart to help structure the discussion.

After all pairs have had an opportunity to role play the scenarios, take a break, then repeat the entire role play scenarios activity with the partners switching roles. (Note: make written notes about each trainee's performance as part of the Trainee Evaluation.)

E. SUMMARY AND REVIEW (15 minutes)

Procedure: 1. Rephrase the objectives on the first page of this unit as questions. Ask a volunteer to answer each question.

2. Distribute the post-unit evaluation forms.

3. Distribute the Post-Unit Test.

DEVELOPMENTAL MILESTONES
One to Four Months

Movement
- Holds self up on forearms when on stomach
- Stretches legs out and kicks when on stomach or back
- Takes some weight on legs when held in standing position
- Holds head steady
- Swipes at objects with hands

Vision
- Watches faces intently
- Looks at hand and object when grasping
- Follows moving objects
- Looks from one object to another
- Recognizes mother and other familiar adults

Hearing and Making Sounds
- Smiles in response to familiar voices
- Anticipates sounds associated with feeding
- Cries differently to express hunger, irritation, pain
- Expresses pleasure by cooing, squealing, gurgling
- Calls for attention
- Takes turns vocalizing with a familiar adult

Emotional and Social Development
- Smiles in response to familiar voices
- Enjoys playing with people; may cry when play stops
- Imitates some movements and facial expressions

DEVELOPMENTAL ALERTS

This is a checklist that the PSS can use when observing a client's child on her 3 month visit. Remember that all children are different, so it's not essential that each baby is able to do everything on this list at a given month. But if the PSS observes children who cannot do many of the things suitable for their age, she should encourage her clients to talk to their health care providers about their babies' development.

3 MONTHS:

- ☐ **When the baby lies on his back, does he move each of his arms and legs equally well? (Notice if the baby uses only one arm or leg or if his movements are jerky).**
- ☐ **When you hold the baby upright does he hold his head up for a few seconds?**
- ☐ **Does the baby smile when he sees his mother's face or hears her voice?**
- ☐ **Does the baby coo and gurgle, in addition to crying?**
- ☐ **Does the baby follow a moving object with his eyes?**

Reprinted with permission from: Weitzberg, B. (1992). "Exploring the World of Infants and Toddlers: A Training Manual about Infants, Toddlers, and their Parents," Baltimore, Maryland: Friends of the Family, Inc., p. 128.

DEVELOPMENTAL HEALTH WATCH

One to Four Months

Although each baby develops in his own individual way and at his own rate, failure to reach certain milestones may signal medical or developmental problems requiring special attention. If you notice any of the following warning signs in your infant at this age, discuss them with your pediatrician.

- Still has Moro reflex after four months
- Doesn't seem to respond to loud sounds
- Doesn't notice his hands by two months
- Doesn't smile at the sound of your voice by two months
- Doesn't follow moving objects with his eyes by two to three months
- Doesn't grasp and hold objects by three months
- Doesn't smile at people by three months
- Cannot support his head well at three months
- Doesn't reach for and grasp toys by three to four months
- Doesn't bring objects to his mouth by four months
- Doesn't push down with his legs when his feet are placed on a firm surface by four months
- Has trouble moving one or both eyes in all directions
- Crosses his eyes most of the time. (Occasional crossing of the eyes is normal in these first months.)
- Doesn't pay attention to new faces, or seems very frightened by new faces or surroundings
- Still has the tonic neck reflex at four to five months

Reprinted with permission from: Shelov, S.P. & Hannemann, R.E. (1991). *Caring For Your Baby and Child: Birth to Age Five*. New York: Bantam Books, p. 180.

SAFETY CHECK

One to Four Months

Falls

- Never place the baby in an infant seat on a table, chair, or any other surface above floor level.
- Never leave your baby unattended on a bed, couch, table, or chair.

Burns

- Never hold your baby while smoking, drinking a hot liquid, or cooking by a hot stove or oven.
- Never allow anyone to smoke around your baby.
- Before placing your baby in the bath, always test the water temperature with the inside of your wrist or forearm.
- Never heat your baby's milk (or, later on, food), in a microwave oven.

Choking

- Routinely check all toys for sharp edges or small parts that could be pulled or broken off.
- If you use a crib gym or other suspended toys for the crib, make sure they are fastened securely and tightly so the baby cannot pull them down or entangle himself in them.

IMMUNIZATION ALERT

At two months, and again at four months, your baby should receive:

- DTP vaccine
- Oral polio vaccine
- HBCV (previously called Hib). (This may cause a slight fever and some soreness where it's injected. The vaccine helps prevents meningitis, pneumonia, and joint infection caused by *Haemophilus influenza* bacteria.

Reprinted with permission from: Shelov, S.P. & Hannemann, R.E. (1991). Caring for Your Baby and Young Child: Birth to Age 5. New York: Bantam Books, pp. 187 and 188.

HELPING PARENTS TO BE PARENTS

The following guidelines illustrate some ways that PSS's can help their clients become more successful parents.

1. **Give the idea of being a mother or father positive meaning and identity.**

Help parents feel like parents -- admire them. Give them credit for what they do, have fun together with the infant, and reassure them that their infant is doing well.

Indirect comments are useful. Don't just admire the baby. As you say something positive about the baby, credit the parents. For example:

- "Mommy dressed you so warmly today. She knows exactly what you need in this cold weather."
- "You are so big; Mommy knows exactly how to feed you to make you grow."
- "You are so nice and clean; Daddy knows exactly how to give you a bath."
- Other examples?

2. **Make the mother and father feel special.**

Support and encourage the attachment between parent and child. For example:

- As the baby smiles at the parent you might say, "Mommy gets the best smiles from you! I know how much she loves you!"
- When the baby looks at your new or strange face say, "You sure know your Mommy best of all. I can see you staring at me. You don't know me at all!"
- When the baby fusses you can say, "Mommy knows how to comfort you best of all," as you guide and support her response to calm the infant.
- Other examples?

3. **Focus on the infant or parent's experience and not on right or wrong.**

Communicate to your clients the fact that babies have feelings by "talking through the baby." This means that the PSS talks as though she were the infant. For example:

- "Hold me tight. I like to be wrapped up tightly too."
- "Don't turn me so fast. It's scary and I'm afraid I'll fall."
- "Lunch was delicious. I really love your milk, Mommy."
- Other examples?

4. **Focus on issues relevant to the baby's specific stage of development.**

To help parents learn to read the baby's cues and signals you might say:

- "You want to tell Daddy something, don't you?"
- "Look how he turns around to look for you just after he crawled away. He's making sure you're still there."
- "You need your Mommy's help, don't you?"
- Other examples?

5. **Focus on how the present behavior of a client's baby will impact on the future.**

- If you see the baby with a book you can say, "When you grow up you're going to be so smart because Mommy is already getting you ready!" By saying this, you can encourage the reading of books to the baby.
- If the baby pounds on a toy, "Mommy is so good with tools and you are following in her foot steps."
- Other examples?

6. **Build the parents' self-esteem by selecting and admiring success.**

Every time a child is doing well, point it out and paint a picture of the child as a successful learner and the mother (or father) as a successful parent.

- "You really got him to listen when you got his attention first, before asking him to do something."
- "You really taught her how to put away her toys when she's done playing."
- Other examples?

IN SUMMARY:

✓ Admire parents.

✓ Credit parents for things they do for their children.

✓ Point out to mothers and fathers how special they are to their children.

✓ Build a successful image of parents -- parents who can be effective and help their children grow and learn.

Reprinted with permission from: Weitzberg, B. (1992). *Exploring the World of Infants and Toddlers: A Training Manual About Infants, Toddlers, and their Parents*, Baltimore, Maryland: Friends of the Family, Inc., pp. 55-56.

WORKING WITH PARENTS

- Parents usually want the best for their children. The parent and the family are the constants in the child's life, whereas the service providers and systems fluctuate (National Center For Family-Centered Care, 1990).
- Most parents want to be better parents (Curran, 1989).
- The professional's ability to listen and hear the parent is equally or more important than teaching, telling, or advising.
- It is important to elicit the parent's views about their child and their experience with the child. "Tell me what life is like for you and the baby." (Trout, 1987).
- We often need to restrain our impulse to criticize and correct the parents' handling of their baby (Arnold, 1978).
- Parents find criticism painful and are apt to react negatively to it (Curran, 1989).
- Most parents know their own children better than anyone else does (Curran, 1989).
- Parents want support more than information (Curran, 1989).
- "It is important . . . to be aware of the goals and priorities that parents have established for their own infant, " (Bronwich, 1984). Offer help in response to family-identified needs (Dunst *et al.*, 1988).
- "Parents should participate as much as possible in the planning of activities for their infant," (Bromwich, 1984).
- "Recognition of parents' strengths . . . are paramount in intervention that purports to help parents feel and be more competent," (Bromwich, 1984).
- The individual style of each parent-infant dyad should be recognized and respected so that intervention can support as well as be in harmony with the style (Bromwich, 1984).
- "Parents should become aware of their own actions and behaviors that are particularly beneficial to the infant," (Bromwich, 1984).
- "Parents should not feel a sense of failure as a result of a staff suggestion that may not work in a particular family," (Bromwich, 1984).
- "We may need to recognize that the best hope of fulfillment of our educational or medical goals may lie in attending to the psychology of the family first—in our willingness to get up off the floor (where we are more comfortable with the child) and onto a chair (where we must look right into the eyes of the parent), where we ask, "How has it been for you? Teach me about your life with this child?" ("Trout, 1987).

Reprinted with permission from: Weitzberg, B. 1992. *Exploring the World of Infants and Toddlers: A Training Manual About Infants, Toddlers, and their Parents*, Baltimore, Maryland: Friends of the Family, Inc., p.63.

CHILD DEVELOPMENT SCENARIOS

How can the PSS help in the following situations?

1. Sara has a 2 month old baby. She complains that while feeding the baby she looks away from Sara. She seems very upset when she tells you this.

2. Susan is the mother of a 6 week old baby. In the past 2 weeks he has been crying for 2-3 hours at the end of each day. She has tried to feed him, rock him and sing to him but nothing seems to help.

3. Adeena is worried that 3 month old David doesn't keep his head up when she sits him up. She makes him sit a lot to practice.

4. Talia hasn't put any toys or pictures around Michael's crib or room. She reads a magazine while she feeds him.

5. Deanne has had her baby Donnie sleeping in bed with her. Now that he is 3 months old she thought he was ready to sleep in his crib. Now he cries until she brings him in bed with her and then he goes to sleep. She wonders what she should do.

6. Toya finds that 3 month old Lakeisha will play with a rattle for a few minutes but then starts to fuss to be picked up. Toya is trying to get some housework done. Toya is frustrated and doesn't know what to do.

7. Angela would like to give the baby a chance to play on his tummy on the floor. She gets out an old crib quilt to lay on the floor for a mat. Her mother says that the floor is too drafty and that the baby will catch a cold. Angela asks you how to handle this.

8. 3 year old Darnell is fascinated by his baby brother Juwan. When Darnell talks to Juwan, he puts his face right up close to his brother's. The baby starts to cry. This makes their mother angry. What might you suggest?

PIP TRAINING
SITE VISIT OBSERVATION

Name of Setting:

Age of Child Observing:

Number of Children:

Number of Adults:

---

1. Observe the environment carefully; look at facilities, materials and personnel. In what way(s) is it appropriate for:

    a. Children's play and interaction:

    b. Daily caretaking:

    c. Safety:

Is it inappropriate in any way?

a. Children's play and interaction:

b. Daily caretaking:

c. Safety:

2. Describe the personality or interaction style of the baby you observe.

3. What do the caregivers do to encourage the baby's development?

4. For the specific baby you observe, what skills do you see s/he has?
    a. Motor:
    b. Cognitive:
    c. Emotional:
    d. Social:
    e. Communication:

5. Do you notice that the child has preferences?

	What the Child Prefers	**How Do You Know**
For Toys or People?		
For Specific Toys?		

6. Do you have any concerns about the baby? What are they? Why are you concerned?

EVALUATION OF TEACHING MATERIALS

WERE THE MATERIALS EASY TO UNDERSTAND?

WHICH ONES DID YOU LIKE BEST AND WHY?

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

UNIT TEST

Child Growth and Development
One Month to Four Months

1. List 5 major developmental milestones during the 1-4 month period.

2. How can parents and caregivers help infants develop optimally at this stage?

3. What changes occur in the baby at this stage that require changes in parenting?

4. Describe 3 specific ways a parent can help her baby's development during this period.

5. How can a PSS work with parents to encourage their growing attachment to their baby?

6. List 3 developmental observations about which a PSS should be concerned.

POST-UNIT EVALUATION

UNIT COVERED: _____

DATE______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

Unit 17

CHILD GROWTH AND DEVELOPMENT: FOUR TO EIGHT MONTHS

In this unit, participants will review developmental milestones of infancy, learn how to help parents understand stages of development and interpret infant behavior, share activities that both parents and their babies will enjoy, recognize possible problems in infant growth and development and identify available resources for babies and parenting families.

Objectives

By the end of this unit, participants will be able to:

- List the major developmental milestones during the four to eight month period.
- Describe and demonstrate ways in which parents can support their child's development at various stages, particularly through the use of play.
- Describe how the developmental milestones in this period require changes in parenting approaches.
- Demonstrate how to talk to mothers about ways to play and interact with their infants during this stage.
- Demonstrate an understanding of the continuity of development, of how developmental milestones at this stage relate to those in the stages before and after this stage.
- List three possible developmental problems to which Parenting Support Specialists should be alert during this stage.
- Demonstrate developmentally appropriate play and interaction with an infant at this stage of development.

Time

32 hours

Outline

A. Developmental Milestones
B. Providing Guidance and Support
C. Site Visit
D. Summary and Review

Materials

- Resource Mothers. (1993). Resource Mothers Handbook (Ch. 14). Sterling, VA: INMED.
- Resource Mothers . (1993). Resource Mothers Curriculum Sourcebook (Ch. 12). Sterling, VA: INMED.
- Shelov, S.P. & Hanneman, R.E. (1991). American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5, (pp. 189-214). N.Y.: Bantam Books.
- Video: "The Developing Child-Infancy" Unit C; Magna Systems West County Lane 95, Barrington, IL 60010
- Timeline for posting on wall
- Growth Chart for Babies

- Weitzberg, B. (1992). Exploring the World of Infants and Toddlers: A Training Manual about Infants, Toddlers and their Parents. Baltimore, MD: Friends of the Family, Inc.
- Developmental tasks written on post-it notes
- Developmental Milestones **(Handout #1)**
- Helping Parents to Be Parents **(Handout #2)**
- Developmental Alerts **(Handout #3)**
- Developmental Health Watch **(Handout #4)**
- Safety Check and Immunization Alert **(Handout #5)**
- PIP Site Observation Form **(Handout #6)**
- Role Play Feedback **(Overhead #1)**
- Post-Unit Test
- Post-Unit Evaluation
- Blackboard and chalk or newsprint, markers and tape
- Variety of books on development, curriculum, toys, etc. including:
  Sparling, J. & Lewis, I. (1984). Partners for Learning Kit. Winston-Salem, NC: Kaplan Press.

Advance Preparation

- Review Chapter 14, "Child Growth and Development" of the *Resource Mothers Handbook* and ask trainees to review it ahead of time.
- Review Resource Mothers Curriculum Sourcebook, Unit 12, "Child Growth and Development."
- Review Chapter 8, "Age Four Months Through Seven Months," pp. 189-213, of *Caring for Your Baby and Young Child.*
- Review Exploring the World of Infants & Toddlers, pp. 46-63.
- Review video: The Developing Child-Infancy.
- Make a timeline for birth to one year to place on the wall. Write developmental tasks on post-it notes for participants to place on the timeline.
- Review Partners in Learning Manual & Accompanying Cards.
- Arrange to have 4-8 months old infants and their mothers join group for an hour.
- Make sufficient copies of any handouts to be used.
- Bring a copy of S.P. Shelov and R.E. Hannemann's *American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5.*
- Bring books, curriculum guides, kits and other materials available to Parenting Support Specialists to use with mothers and babies.

A. DEVELOPMENTAL MILESTONES (14 hours)

Rationale: Give the Parenting Support Specialists a framework into which to fit the detailed information which is to follow by introducing the 4 to 8 month old baby based on information in **Caring for Your Baby and Young Child** pp. 189-190.

- predictable routine allows baby to feel secure
- but important to baby and mother to be flexible, adapt to change
- coordinates vision, hearing and motor
- makes choices
- communicates better
- stranger awareness (6 mos.), stranger anxiety (8 mos.)
- each baby is unique and requires different parenting

1. APPEARANCE

Rationale: Mothers will continue to notice changes in their baby's physical appearance during these early months. Parenting Support Specialists can help mothers know what to expect.

Procedure: **Mini-lecture**. Babies should continue to gain about 1 to 1 1/4 pounds a month. By 8 months, the baby will weigh about 2 ½ times what he weighed at birth. His bones continue to grow. He will get about 2 inches longer during this period and his head will grow about an inch. (Refer to Growth Chart).

How much the baby grows is not as important as the rate of growth. Each time the mother goes to the doctor, he will plot the baby's height, weight and head circumference on a growth curve to be sure the baby is following the same curve.

2. SKILL AREAS

Rationale: Understanding normal growth and development will help PSSs interpret baby's behavior to parents.

Procedure: a. **Timeline Activity** Ask participants to choose a partner. In teams, have participants place various developmental tasks from birth to 8 months (written on post-it notes) at the approximate age where they first appear on a timeline posted on the wall. The timeline should include each month from birth to two years of age. (Save this timeline and use it in future sessions.)

When all developmental tasks have been placed, ask the participants to look at the timeline and, following discussion, make any changes they wish. Tell them that we will review the timeline at set periods during the day and they can make further changes during these times.

b. **Mini-lecture and demonstration.** Review the developmental milestones presented in **Caring for Your Baby and Child**, pp. 191-202. Give each participant a copy of *Developmental Milestones* **(Handout #1)**. Include Movement, Vision, Language Development, Cognitive Development, and Emotional Development. Write these categories on a flip chart and tape this paper to the wall in the front of the room.

Discuss and demonstrate the skills in each of the developmental area. Use appropriate toys to show skills, ask participants to give examples of skills from their own family or experience with children, and connect present skills to development during the first four months.

Review the relationship between object permanence and separation anxiety, and between development of the pincer grasp and introduction of finger feeding.

c. **Videotape and discussion**. Show a typical 4-8 month old baby using the video, "The Developing Child-Infancy." Ask the trainees what skills they observe in each developmental area. Process their responses by writing them on the flip chart. Participants may discover that some observed skills can represent more than one area. Stress the inter-relatedness of skills throughout infant development.

d. Activity: Review of Timeline. Ask participants to look at the Developmental Milestones **(Handout #1)** they have and check the placement of the developmental tasks on the timeline. Tell them to change any they now think should be in a different place. Discuss any differences of opinion stressing the individuality of each child and the range in which skills normally develop.

3. DEVELOPMENTAL ALERTS (2 hours)

Rationale: Since PSSs will be seeing mothers and babies regularly. Their knowledge of developmental alerts can help them identify potential problems that could result in needed intervention.

Procedure: a. **Discussion.** Remind participants that each baby is an individual and will develop at his own rate. However, there may be times when the Parenting Support Specialist is concerned about a baby during this time of 4 to 8 months. Ask participants to tell you what they would consider warning signs for medical or developmental problems during this period. Process their answers by writing them on the flip chart.

b. **Activity.** Refer each participant to their copy of the *Developmental Alerts Handout* **(Handout #3)** from Resource Mothers Unit 12 and the *Developmental Health Watch* **(Handout #4)** from p. 200-1 of **Caring for Your Baby and Child**. Ask them to incorporate the Alerts from Resource Mothers into the longer

Developmental Health Watch List, then match any warning signs that were listed by the trainees to the ones included on the charts.

Discuss each of the developmental alerts and health watch points. Have participants point out into which development area each health watch fits. Answer any questions they have about what is normal or typical development and when they should be concerned. Also, introduce basic special needs vocabulary such as cerebral palsy, mental retardation, autism, etc.

c. **Activity.** Refer each participant to their copy of *Safety Check* **(Handout #5)** from p. 213-214 of **Caring for Your Baby and Child**. Discuss each item. Ask participants why they think it might be difficult for the mothers with whom they are working to follow these safety rules? How might they encourage them to follow the rules? Ask them to be specific. Give each participant "Immunization Alert" **(Handout #5)**. Review.

B. PROVIDING GUIDANCE AND SUPPORT (7 hours)

Rationale: In this part of the training, participants will examine ways to interact with infants and with parents around child development issues. As pointed out in the Resource Mothers training, it is important for Parenting Support Specialists to learn how to support and encourage without undermining the self-esteem of the parents.

Procedure: 1. **Preparation for "Providing Guidance and Support"**. Explain the activities to be done in Providing Guidance and Support. Have books, curricula, kits and other developmental materials to be used available for review by trainees.

2. **Review of Developmental Milestones** as they appear on the flipchart and timeline.

Discussion of feeding as it relates to this age level:

- Introduce solid foods slowly and in small quantities
- Primary nutrition continues to be from breast or bottle and will be for the 1st year
- When introducing foods, introduce one new food every 3 to 5 days
- Always refrigerate open baby food
- When using jar baby food, do not feed from the jar, but remove portion to be eaten and refrigerate the rest.

Discuss Behavior and Discipline as presented on pages 211 and 212 of **Caring for Your Baby and Young Child** as well as other relevant information for this age such as:

- Discipline is a gift to a child, not punishment:
  - Reward good behavior and teach limits
  - Parents need to first establish routine behavior; use "no" or "no [illegible]" simple short language (offering a distraction after saying "no" is important for this age)
  - Parents must have appropriate expectations, one very important reason why knowing child development is so important.
- Present short scenarios for group. After each scenario ask: Are expectations realistic? What should happen?
  - 7 month old has a sock in mouth; mom screams "no" and takes sock away or says, "Don't put that in your mouth!", and gives no substitute.
  - 8 month old commando crawls and ends up under a table. Mom yells at him, puts him back on blanket, and tells him to stay still.
  - There are little balls all over floor. Baby touches one, starts to put in month. Mom yells, "Don't touch those balls".

This topic will be covered in detail in a later Unit.

3. Mini-discussion. If Parenting Support Specialists understand the usual course of development, they can make judgements about what kinds of play and interaction will facilitate development and can help guide the parents whom they work with.

Ask participants to think about the 4-8 month old: How might parents best play with their babies during this time? What are some toys that might encourage the baby to develop skills appropriately?

4. Use the Partners in Learning Curriculum cards (1 hour)
Describe the format of the curriculum cards and how they will be used on the home visits. Review the developmental functioning areas that are targeted by the activities. Ask the group to name the area being targeted by some sample activity cards.

Role plays with Partners cards (1 hour)
Divide the group into pairs and give a Partners card to each PSS. Have each pair role play for the group with one person being the mother and the other PSS presenting the Partners activity for that visit. Have the group comment on each role play. Use **Overhead #1** to guide feedback.

Baby demonstrations (1 hour)
Arrange to have a normal infant between 4 and 8 months join the group to demonstrate developmental skills characteristic of this age range. Point out the infants social interactive capability at this age, how she/he uses toys, the type of vocal behaviors she/he demonstrates, and her/his gross motor skills. Have each of the PSSs engage the infant in an activity. Be sure to have some appropriate toys available.

5. What is perception? Discuss idea of different perceptions, particularly of mothers, PSSs, daycare workers.

- When attempting to relate to another person:
  - don't assume!!!
  - elicit information in nonjudgemental way
  - reflect
  - validate
  - clarify
  - establish clear boundaries; make referrals

- What goes into our perceptions
  - Experience past and present -- may lead to certain associations
  - Your own temperament
  - Daily issues -- internal and external
  - Role in situations

C. SITE VISIT (7 hours)

Rationale: Observing infants and caregivers at this stage will make the information more meaningful to the PSSs.

Procedure: Participants visit day care center, day care homes, or other programs to observe typically-developing infants from four to eight months old. Participants may all visit one center or go to two or more to different centers. A member of the Pride in Parenting training staff should be present for part of the time or should ensure that on-site staff are able to guide trainees in observation and interaction with infants. Ask each participant to focus on one child as they follow along the site visit observation form **(Handout #6)**.

After everyone has completed their site visit, come together as a group. Ask each participant to discuss the child(ren) she observed and the developmental milestones she observed. How did the parent/caregiver facilitate the child's development? Return to the site observations when talking about developmental alerts.

D. SUMMARY AND REVIEW (15 minutes)

Procedure: 1. Rephrase the objectives on the first page of this unit as questions. Ask a volunteer to answer each question. Ask group if there is any information they still need on growth and development of 4 to 8 month old infant.

2. Distribute post-unit test.

3. Distribute the post-unit evaluation forms.

DEVELOPMENTAL MILESTONES

Four to Eight Months

By the End of This Period

Movement
- Brings hands to feet and feet to mouth
- Reaches for toy with one or both hands
- Rolls stomach to back and back to stomach
- Sits alone and plays with toy
- Able to hold a small object in each hand
- Bangs objects in play
- Brings hands across midline
- Tries to pick up small objects

Cognition
- Anticipates routines when sees familiar objects (bottle)
- Explores objects by mouthing, shaking and banging
- Finds a toy that has been partially hidden
- Begins to understand the concept of simple games (peek-a-boo)
- Imitates vocalizations and actions
- Recognizes self in mirror

Communication
- Babbles strings of sounds (da-da-da-da)
- Begins to imitate sounds
- Smiles and laughs during play
- Stops crying when talked to
- Responds to own name
- Recognizes a few familiar words (bye-bye, mommy)

Emotional and Social Development
- Knows primary caregiver from others
- Shows mild to severe anxiety at separation
- Infant to infant interaction increases
- May cry when left alone or put down
- Shows awareness of strange environments

HELPING PARENTS TO BE PARENTS

The following guidelines illustrate some ways that PSSs can help their clients become more successful parents.

1. **Give the idea of being a mother or father positive meaning and identity.**

   Help parents feel like parents -- admire them. Give them credit for what they do, have fun together with the infant, and reassure them that their infant is doing well.

   Indirect comments are useful. Don't just admire the baby. As you say something positive about the baby, credit the parents. For example:
   - "Mommy dressed you so warmly today. She knows exactly what you need in this cold weather."
   - "You are so big; Mommy knows exactly how to feed you to make you grow."
   - "You are so nice and clean; Daddy knows exactly how to give you a bath."
   - Other examples?

2. **Make the mother and father feel special.**

   Support and encourage the attachment between parent and child. For example:
   - As the baby smiles at the parent you might say, "Mommy gets the best smiles from you! I know how much she loves you!"
   - When the baby looks at your new or strange face say, "You sure know your Mommy best of all. I can see you staring at me. You don't know me at all!"
   - When the baby fusses you can say, "Mommy knows how to comfort you best of all," as you guide and support her response to calm the infant.
   - Other examples?

3. **Focus on the infant or parent's experience and not on right or wrong.**

   Communicate to your clients the fact that babies have feelings by "talking through the baby." This means that the PSS talks as though she were the infant. For example:
   - "Hold me tight. I like to be wrapped up tightly too."
   - "Don't turn me so fast. It's scary and I'm afraid I'll fall."
   - "Lunch was delicious. I really love your milk, Mommy."
   - Other examples?

Adapted from: Weitzberg, B. (1992). "Exploring the World of Infants and Toddlers: A Training Manual About Infants, Toddlers, and their Parents," Baltimore, Maryland: Friends of the Family, Inc., pp. 55-56.

4. **Focus on issues relevant to the baby's specific stage of development.**

To help parents learn to read the baby's cues and signals you might say:
- "You want to tell Daddy something, don't you?"
- "Look how he turns around to look for you just after he crawled away. He's making sure you're still there."
- "You need your Mommy's help, don't you?"
- Other examples?

5. **Focus on how the present behavior of a client's baby will impact on the future.**

- If you see the baby with a book you can say, "When you grow up you're going to be so smart because Mommy is already getting you ready!" By saying this, you can encourage the reading of books to the baby.
- If the baby pounds on a toy, "Mommy is so good with tools and you are following in her foot steps."
- Other examples?

6. **Build the parents' self-esteem by selecting and admiring success.**

Every time a child is doing well, point it out and paint a picture of the child as a successful learner and the mother (or father) as a successful parent.
- "You really got him to listen when you got his attention first, before asking him to do something."
- "You really taught her how to put away her toys when she's done playing."
- Other examples?

IN SUMMARY:

✓ Admire parents.

✓ Credit parents for things they do for their children.

✓ Point out to mothers and fathers how special they are to their children.

✓ Build a successful image of parents -- parents who can be effective and help their children grow and learn

Adapted from: Weitzberg, B. (1992). "Exploring the World of Infants and Toddlers: A Training Manual About Infants, Toddlers, and their Parents," Baltimore, Maryland: Friends of the Family, Inc., pp. 55-56.

DEVELOPMENTAL ALERTS

This is a checklist that the PSS can use when observing a client's child on her 6 month visit. Remember that all children are different, so it's not essential that each baby is able to do everything on this list at a given month. But if the PSS observes children who cannot do **many** of the things suitable for their age, she should encourage her clients to talk to their health care providers about their babies' development.

6 MONTHS:

- ☐ **Have you seen the baby play with her hands by touching them together?**
- ☐ **Has the baby rolled over at least twice, from stomach to back or back to stomach?**
- ☐ **Does the baby respond to sounds?**
- ☐ **Does the baby see small things such as crumbs left on the floor?**
- ☐ **Does the baby reach for objects or familiar people?**

Adapted from: Weitzberg, B. (1992). "Exploring the World of Infants and Toddlers: A Training Manual About Infants, Toddlers, and their Parents," Baltimore, Maryland: Friends of the Family, Inc., p.128.

DEVELOPMENTAL HEALTH WATCH

Four to Eight Months

- Seems very stiff, with tight muscles
- Seems very floppy, like a rag doll
- Head still flops back when body is pulled up to a sitting position
- Reaches with one hand only
- Refuses to cuddle
- Shows no affection for the person who cares for him
- Doesn't seem to enjoy being around people
- One or both eyes consistently turn in or out
- Persistent tearing, eye drainage, or sensitivity to light
- Does not respond to sounds around him
- Has difficulty getting objects to his mouth
- Does not turn his head to locate sounds by four months
- Doesn't roll over in either direction (front to back or back to front) by five months
- Seems inconsolable at night after five months
- Doesn't smile spontaneously by five months
- Cannot sit with help by six months
- Does not laugh or make squealing sounds by six months
- Does not actively reach for objects by six to seven months
- Doesn't follow objects with both eyes at near (1 foot) and far (6 feet) ranges by seven months.
- Does not bear some weight on legs by seven months
- Does not try to attract attention through actions by seven months
- Does not babble by eight months
- Shows no interest in games of peekaboo by eight months

Source: Shelov, S.P. & Hannemann, R.E. (1991). Caring For Your Baby and Child: Birth to Age Five. New York: Bantam Books, pp. 200 and 201.

SAFETY CHECK

Four to Eight Months

Car Seats

- Buckle the baby into an approved, properly installed car seat before you start the car. Keep the seat in backward-facing position until the child is able to sit independently.

Drowning

- Never leave a baby alone in a bath or near a pool of water, no matter how shallow it is. Infants can drown in just a few inches of water.

Falls

- Never leave a baby unattended in high places, such as on a tabletop or in a crib with the sides down. If he does fall, and seems to be acting abnormally in any way, call the pediatrician immediately.

Burns

- Never smoke, eat, drink, or carry anything hot while holding a baby.

- Prevent scalding by reducing the water heater setting to 120 degrees or lower.

Choking

- Never give a baby any food or small object that could cause choking. All foods should be mashed, ground, or soft enough to swallow without chewing.

IMMUNIZATION ALERT

At four months your baby should receive:

- Second DTP injection
- Second oral polio vaccine
- Second HBCV injection

And at six months:

- Third DTP injection
- Third oral polio vaccine (only in high-risk areas)
- Third HBCV injection

Source: Shelov, S.P. & Hannemann, R.E. (1991). Caring For Your Baby and Child: Birth to Age Five. New York: Bantam Books, pp. 213 and 214.

PIP TRAINING
SITE VISIT OBSERVATION

Name of Setting:

Age of Child Observing:

Number of Children:

Number of Adults:

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1. Observe the environment carefully; look at facilities, materials and personnel. In what way(s) is it appropriate for:

   a. Children's play and interaction:

   b. Daily caretaking:

   c. Safety:

Are there ways it is inappropriate?

   a. Children's play and interaction:

   b. Daily caretaking:

   c. Safety:

2. Describe the personality or interaction style of the baby you observe.

3. What do the caregivers do to encourage the baby's development?

4. For the specific baby you observe, what skills do you see s/he has?

   a. Motor:

   b. Cognitive:

   c. Emotional:

   d. Social:

   e. Communication:

5. Do you notice that the child has preferences?

	What the Child Prefers	How Do You Know
For Toys or People?		
For Specific Toys?		

6. Do you have any concerns about the baby? What are they? Why are you concerned?

BEST COPY AVAILABLE

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

POST-UNIT TEST

1. List 5 major developmental milestones during the 4 to 8 month period.

2. List 3 specific ways a parent can help her baby develop during this period.

3. What changes occur in the baby at this stage of development that require changes in parenting?

4. How can a PSS work with parents to encourage their growing attachment to their baby?

5. List 3 developmental observations about which a PSS should be concerned.

POST-UNIT EVALUATION

UNIT COVERED: _____

DATE______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

Unit 18
CHILD GROWTH AND DEVELOPMENT: EIGHT TO TWELVE MONTHS

In this unit, participants will review developmental milestones of 8-12 months, learn how to help parents understand stages of development and interpret infant behavior, share activities that both parents and their babies will enjoy, recognize possible problems in infant growth and development and identify available resources for babies and parenting families.

Objectives

By the end of this unit, participants will be able to:

- List the major developmental milestones during the eight to twelve month period.
- Describe and demonstrate ways in which parents can support their child's development at various stages, particularly through the use of play.
- Describe how the developmental milestones in this period require changes in parenting approaches.
- Demonstrate how to talk to mothers about ways to play and interact with their infants during this stage.
- Demonstrate an understanding of the continuity of development, of how developmental milestones at this stage relate to those in the stages before and after this stage.
- List three possible developmental problems to which Parenting Support Specialists should be alert during this stage.
- Demonstrate developmentally appropriate play and interaction with an infant at this stage of development.

Time

35 hours

Outline

A. Developmental Milestones
B. Developmental Alerts
C. Site Visit
D. Providing Guidance and Support
E. Summary and Review

Materials

- Have 1 or 2 brief articles on Separation Anxiety such as:
- Dusorkin, P. (1992). Coping with separation and stranger anxiety. Healthy Kids Birth, Vol.3 (pp. 70 & 72)..
- Klavan, E. (1980). Separation anxiety. American Baby, pp 33-34.
- Resource Mothers. (1993). Resource Mothers Handbook. Sterling, VA: INMED.
- Resource Mothers. (1993). Resource Mothers Curriculum Sourcebook. Sterling, VA: INMED.
- Shelov, S.P. & Hanneman, R.E. (1991). American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5, (pp. 215-247). N.Y.: Bantam Books.

- Weitzberg, B. (1992). Exploring the World of Infants and Toddlers: A Training Manual about Infants, Toddlers and their Parents. Baltimore, MD: Friends of the Family, Inc.
- Video: *Babies Are People Too*, Churchill Media, 12210 Nebraska Avenue, Los Angeles 90025.
- Timeline posted on wall with Developmental Tasks written on post-it notes
- Parks, S. (Ed.) (1988). HELP . . . at Home . Vort Corporation.
- Jacobs, S.H. & Adams, B. (1991). Your Baby's Mind. Holbrook, MA.
- Developmental Milestones **(Handout #1)**
- Helping Parents to Be Parents **(Handout #2)**
- Developmental Alerts **(Handout #3)**
- Developmental Health Watch **(Handout #4)**
- Safety Check **(Handout #5)**
- Child Development Scenarios **(Handout #6)**
- Site Visit Observation Form **(Handout #7)**
- Language Development **(Handout #8)**
- Evaluation of Teaching Materials **(Overhead #1)**
- Role Play Feedback **(Overhead #2)**
- Post-Unit Test
- Post-Unit Evaluation
- Blackboard and chalk or newsprint, makers and tape.

Advance Preparation

- Review Chapter 14, "Child Growth and Development" of the *Resource Mothers Handbook* and ask trainees to review it ahead of time.
- Review *Resource Mothers Curriculum Sourcebook*, Unit 12, "Child Growth and Development."
- Review *Exploring the World of Infants & Toddlers*, pps. 41-43, 55-56, 125-128
- Review *HELP . . . at Home*, pps. 390, 396, 398-399.
- Review *Caring for Your Baby and Young Child*, Chapter 9, "Age Eight Months Through Twelve Months, pp. 215-247.
- Review *Your Baby's Mind.*
- Review video: *Babies are People Too.*
- Post the timeline for birth to one year on the wall with the developmental tasks on post-it notes placed by the participants.
- Arrange for mothers to bring babies of 8-12 months to a session.
- Make sufficient copies of any handouts to be used.
- Bring a copy of S.P. Shelov and R.E. Hannemann's *American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5.*
- Bring books, curriculum guides, kits and other materials available to Parenting Support Specialists to use with mothers and babies.

A. DEVELOPMENTAL MILESTONES (14 hours)

Rationale: Give the Parenting Support Specialists a framework to fit in the detailed information which is to follow by introducing the 8 to 12 month old baby based on information in **Caring for Your Baby and Young Child**, pp. 215-217. (30 minutes)

- increasingly mobile, crawling and walking
- no concept of danger; limited memory for warnings
- child-proofing home necessary
- emerging self-esteem
- needs help vs. solve own problem

Ask participants: What kind of things can parents do to childproof their homes so that they do not have to continually tell a baby "no"? How is it possible for mothers to make their baby's environment "childproof" when they are living with many other family members? In another person's home? In temporary housing?

1. APPEARANCE

Rationale: Mothers will continue to notice changes in their baby's physical appearance during these early months. Parenting Support Specialists can help mothers know what to expect.

Procedure: **1. Mini-lecture**. Babies should continue to grow rapidly during this period.

- 8 month old boy: 14 ½ to 17 ½ pounds. Girls: ½ pound less.
- 12 months: Tripled birthweight, is 28 to 32 inches tall, head 18" diameter.

Remember: how much the baby grows is not as important as the rate he grows. The doctor will check the growth chart to be sure the baby is following the same curve.

Parents may be worried about:

- Their baby's posture when he begins to stand. His stomach will stick out, his rear end will stick out and he will be "sway backed". This is okay. He will do this until he develops good balance, sometime in the second year.
- The baby's feet turning in when he is lying down; pigeon-toed. This is common and should disappear by 18 months as the child stands and walks.
- The baby's feet turning out when standing. Common when the baby first starts walking. Should look better by about 18 months.
- The baby is "flat-footed". The arch is hidden by a pad of fat at this age. The child should develop an arch by 2 or 3 years.

2. SKILL AREAS (8 hours)

Procedure: a. **Timeline Activity.** Remind participants of the timeline posted on the wall. Ask them to look at the timeline and make any changes they wish following the past few days of training. Tell them that we will review the timeline at set periods during the day and they can make further changes during these times.

b. **Mini-lecture and demonstration** (6 hours). Review the developmental milestones presented in **Caring for Your Baby and Child**, pp. 217-236. Give each participant a copy of the *Developmental Milestone Charts* (**Handout #1**). Include Movement, Hand and Finger Skills, Language, Cognitive, and Social/Emotional Development. Write these categories on a flip chart and tape this paper to the wall in the front of the room.

Discuss and demonstrate the skills in each of the developmental areas. Use appropriate toys to show skills, ask participants to give examples from their own family or experience of toys that are good to encourage skills with children. Connect present skills to development during the first eight months and after twelve months.

c. **Videotape and discussion** (2-3 hours). Show a typical 8-10 month old baby using the video, "Babies are People Too". Ask the trainees what skills they observe in each developmental area. Process their responses by writing them on the flip chart. Participants may discover that some observed skills can represent more than one area. Stress the interrelatedness of skills throughout infant development.

Repeat this activity for a 10-12 month old child.

d. **Live Demonstration** (2-3 hours). Invite three or four mothers to bring their babies to the training session. Have the participants observe the babies playing alone and with their mothers. Then have the participants play with the babies, using toys to get the babies to demonstrate developmental milestones. Participants should note how the baby's interaction differs between the mother and the trainees.

e. **Activity: Review of Timeline.** Ask participants to look at the placement of the developmental tasks on the timeline. Based on the lectures, discussions, demonstrations, and video, ask them to change any they now think should be in a different place. Discuss any differences of opinion stressing the individuality of each child and the range in which skills normally develop.

B. DEVELOPMENTAL ALERTS (5 hours)

Rationale: Since PSSs will be seeing mothers and babies regularly, their knowledge of developmental alerts can help them identify potential problems that could result in needed intervention.

Procedure: 1. **Discussion.** Remind participants that each baby is an individual and will develop at his own rate. However, there may be times when the Parenting Support Specialist is concerned about a baby during this time of 8 to 12 months. Ask participants to tell you what they would consider warning signs for medical or developmental problems during this period. Process their answers by writing them on the flip chart.

2. **Activity.** Refer each participant to their copy of the *Developmental Alerts Handout* **(Handout #3)** from *Resource Mothers* Unit 12 and the *Developmental Health Watch* **(Handout #4)** from p. 237 of *Caring for Your Baby and Child.* Ask them to incorporate the Alerts from Resource Mothers into the longer Developmental Health Watch List, then match any warning signs that were listed by the trainees to the ones included on the charts.

Discuss each of the developmental alerts and health watch points. Answer any questions they have about what is normal or typical development and when they should be concerned. Be sure to include health and emotional issues in discussing why a child's development might be delayed at this age. Briefly mention the following and that these are discussed more fully in other sections of the training: inadequate nutrition, chaotic or violent environment, child abuse, and prenatal exposure to drugs or alcohol.

3. **Activity: Safety and Discipline.** Refer each participant to their copy of *Safety Check* **(Handout #5)** from p. 247 of Caring for Your Baby and Child. Discuss each item. Ask participants why they think it might be difficult for the mothers with whom they are working to follow these safety rules? How might they encourage them to follow the rules? Ask them to be specific.

Discuss Discipline Issues during this period (Caring for Your Baby and Child, p. 244-246). Note the importance of parents having realistic developmental expectations to interpret their infant's behavior. Discuss information from HELP. . . at Home: "Testing During Mealtime", and "Testing at Bedtime".

4. **Role Play Scenarios.** Ask each participant to select a partner or assign partners. One will play the Parenting Support Specialist and the other the mother. Then they will change.

Take slips of folded paper with child development role play scenarios which have been written prior to training. Place them in a container and ask each "mother" to pick one child development scenario **(Handout #6)**.

Give each team 10 to 15 minutes to jot down responses to the scenario.

Bring everyone back together and ask each team to play out its scenario with the mother introducing the scenario to the PSS. The PSS should talk to the mother as she would on a home visit. Following each scenario, process the activity by asking the participants doing the role play, then the rest of the participants, the questions on **Overhead # 2**.

After all pairs have had an opportunity to role play the scenarios, take a break, then repeat the entire role play scenarios activity with the partners switching roles.

C. SITE VISIT (8 hours)

Rationale: Observing infants and caregivers at this stage will make the information more meaningful to the PSSs.

Procedure: 1. Participants visit day care center, day care homes, or other programs to observe typically-developing infants from eight to twelve months old. Participants should focus on developmental milestones, social/emotional behavior, and appropriate toys and play interactions. Distribute **Handout # 7, Site Visit Observation Form**.

2. Participants may all visit one center or go in two's to different centers. A member of the Pride in Parenting training staff should be present for part of the time or should ensure that on-site staff are able to guide trainees in observation and interaction with infants.

3. After the observation, ask each participant to discuss the child(ren) she observed and the developmental milestones she observed. How did the parent/caregiver facilitate the child's development? What else did she observe? Relate site observations to the developmental alerts.

D. PROVIDING GUIDANCE AND SUPPORT (8 hours)

Rationale: In this part of the training, participants will examine ways to interact with infants and with parents around child development issues. As pointed out in the Resource Mothers training, it is important for Parenting Support Specialists to learn how to support and encourage without undermining the self-esteem of the parents.

Procedure: 1. **Review of Developmental Milestones.** Briefly review the milestones from eight to twelve months by writing each developmental area (Movement, Language, Cognitive, Social/Emotional) on a flip chart and asking the participants what they remember the baby is doing in this area during the 8 - 12 month period. Complete each area.

2. **Mini Lecture on Language Development at this Age**. Relate it to cognitive skill development of this age. Be sure to include "communication" as more than just talking. Define receptive, expressive and pragmatic language.

Focus on facilitators of language. Refer to "Exploring the World of Infants and Toddlers", **Handout #8**.

3. **Mini-discussion.** Parents often think that babies at this age can understand and remember things much better than they actually can. They do not realize that the baby cannot control his desire to do what he wants, even though he may know that the parent does not like it. Parents also may think that the baby is

"misbehaving" on purpose, just to make them mad. Include short mini lecture on discipline for this age.

If Parenting Support Specialists understand the usual course of development, not only can they make judgements about what kinds of play and interaction will facilitate development, but they also can help guide parents' expectations of the child.

Ask participants to think about how an 8 to 12 month old baby plays. How might parents best play with their babies during this time? What are some toys that might encourage the baby to develop skills appropriately?

4. Mini-lecture and Discussion: Separation Anxiety. Discuss the predictable periods of separation anxiety using the materials in Caring for Your Baby and Young Child, pp. 229-235 and other child development materials. Review information on attachment. Review "HELP. . . at Home" information on separation anxiety. Ask participants:

- What are some of the usual behaviors of an infant experiencing separation anxiety?
- What can parents and caregivers do to make this period a little easier for the baby--and for the parents and caregivers?!

Process the participants' answers on a flip chart. Include in the discussion baby-sitters, transitional objects and dependence vs. independence at this stage as part of a process of development.

E. SUMMARY AND REVIEW (15 minutes)

Procedure: 1. Rephrase the objectives on the first page of this unit as questions. Ask a volunteer to answer each question.

2. Ask participants whether the learning objectives they stated at the beginning of the unit were met. What information do they feel they still need on growth and development of the eight to twelve month old infant.

3. Distribute the post-unit evaluation forms.

4. Distribute the post-unit test.

DEVELOPMENTAL MILESTONES
Eight to Twelve Months

Movement
- Can get in and out of sitting into other positions
- Crawls forward on stomach
- Creeps on hands and knees
- Pulls to standing
- Walks holding on to furniture (cruises)
- Stands alone and may take a few steps
- Picks up small objects with thumb and index finger (pincer)
- Claps hands together
- Pokes with index finger

Cognition
- Begins to combine objects in play (blocks in bucket, hits drum with stick)
- Performs an action in order to produce a result
- Moves to reach a desired object
- Touches an adult or object to cause action or movement
- Begins to play with toys and use objects correctly (pushes car, drinks from cup)
- Plays exchange games with adults (hands toy back and forth)
- Practices skills over and over

Language
- Responds to simple commands (come here, give me a kiss)
- Looks and stops in response to "no"
- Recognizes the names of familiar objects
- Plays speech-gesture games like patty cake
- Uses exclamations, such as "Oh-oh"!
- Says first word around first birthday
- Has "conversation" with people and toys using jargon (string of sounds with changing tone and pitch)

Emotional and Social
- Shows emerging stranger anxiety through anticipating events (when mother puts coat on)
- Plays unattended for short period
- May refuse to allow self to be distracted; begins showing persistence

HELPING PARENTS TO BE PARENTS

The following guidelines illustrate some ways that PSSs can help their clients become more successful parents.

1. **Give the idea of being a mother or father positive meaning and identity.**

   Help parents feel like parents -- admire them. Give them credit for what they do, have fun together with the infant, and reassure them that their infant is doing well.

   Indirect comments are useful. Don't just admire the baby. As you say something positive about the baby, credit the parents. For example:
   - "Mommy dressed you so warmly today. She knows exactly what you need in this cold weather."
   - "You are so big; Mommy knows exactly how to feed you to make you grow."
   - "You are so nice and clean; Daddy knows exactly how to give you a bath."
   - Other examples?

2. **Make the mother and father feel special.**

   Support and encourage the attachment between parent and child. For example:
   - As the baby smiles at the parent you might say, "Mommy gets the best smiles from you! I know how much she loves you!"
   - When the baby looks at your new or strange face say, "You sure know your Mommy best of all. I can see you staring at me. You don't know me at all!"
   - When the baby fusses you can say, "Mommy knows how to comfort you best of all," as you guide and support her response to calm the infant.
   - Other examples?

3. **Focus on the infant or parent's experience and not on right or wrong.**

   Communicate to your clients the fact that babies have feelings by "talking through the baby." This means that the PSS talks as though she were the infant. For example:
   - "Hold me tight. I like to be wrapped up tightly too."
   - "Don't turn me so fast. It's scary and I'm afraid I'll fall."
   - "Lunch was delicious. I really love your milk, Mommy."
   - Other examples?

4. **Focus on issues relevant to the baby's specific stage of development.**

   To help parents learn to read the baby's cues and signals you might say:
   - "You want to tell Daddy something, don't you?"
   - "Look how he turns around to look for you just after he crawled away. He's making sure you're still there."
   - "You need your Mommy's help, don't you?"
   - Other examples?

5. **Focus on how the present behavior of a client's baby will impact on the future.**

- If you see the baby with a book you can say, "When you grow up you're going to be so smart because Mommy is already getting you ready!" By saying this, you can encourage the reading of books to the baby.
- If the baby pounds on a toy, "Mommy is so good with tools and you are following in her foot steps."
- Other examples?

6. **Build the parents' self-esteem by selecting and admiring success.**

Every time a child is doing well, point it out and paint a picture of the child as a successful learner and the mother (or father) as a successful parent.

- "You really got him to listen when you got his attention first, before asking him to do something."
- "You really taught her how to put away her toys when she's done playing."
- Other examples?

IN SUMMARY:

- ✓ Admire parents.
- ✓ Credit parents for things they do for their children.
- ✓ Point out to mothers and fathers how special they are to their children.
- ✓ Build a successful image of parents -- parents who can be effective and help their children grow and learn.

Reprinted with permission from: Weitzberg, B. (1992). *"Exploring the World of Infants and Toddlers: A Training Manual About Infants, Toddlers, and their Parents,"* Baltimore, Maryland: Friends of the Family, Inc., pp. 55-56.

DEVELOPMENTAL ALERTS

9 MONTHS:

- ☐ **When the baby is playing and you come up quietly behind him, does he sometimes turn his head as though he heard you?**
- ☐ **Does the baby smile, laugh, and babble?**
- ☐ **When the baby lies on his stomach, can he lift and support his body on outstretched arms?**
- ☐ **Does the baby hold his bottle?**
- ☐ **Does the baby reach for and grasp objects?**
- ☐ **Does the baby sit alone?**
- ☐ **Can the baby support some of his weight with his feet when you hold him up?**

12 MONTHS:

- ☐ **When you hide behind something and then reappear, does baby look for you?**
- ☐ **Does the baby make "ma-ma" or "da-da" sounds?**
- ☐ **Does the baby crawl on hands and knees?**
- ☐ **Does the baby pull up to stand?**
- ☐ **Does the baby say one word?**
- ☐ **Does the baby walk holding on to furniture?**
- ☐ **Does the baby turn her head in the correct direction a sound is coming from?**
- ☐ **Does the baby use her finger and thumb to pick up small things?**

Reprinted with permission from: Weitzberg, B. (1992). *"Exploring the World of Infants and Toddlers: A Training Manual About Infants, Toddlers, and their Parents,"* Baltimore, Maryland: Friends of the Family, Inc., pp. 128-129.

DEVELOPMENTAL HEALTH WATCH
Eight to Twelve Months

- Does not crawl
- Drags one side of body while crawling (for over one month)
- Cannot stand when supported
- Does not search for objects that are hidden while he watches
- Says no single words ("mama" or "dada")
- Does not learn to use gestures, such as waving or shaking head
- Does not point to objects or pictures

Reprinted with permission from: Shelov, S.P. & Hannemann, R.E. (1991). Caring For Your Baby and Child: Birth to Age Five. New York: Bantam Books, p. 237.

SAFETY CHECK
Eight to Twelve Months

Car Seats

- Buckle the baby into an approved, properly installed car seat before you start the car. Since he sits up without assistance at this age, he can be facing forward. Children still need to be in the back seat of any vehicle.

Falls

- Use gates at the top and bottom of stairways, and to doors of rooms with furniture or other objects that the baby might climb on or that have sharp or hard edges against which he might fall.

Burns

- Never carry hot liquids or foods near your baby or while you're holding him.
- Never leave containers of hot liquids or foods near the edges of tables or counters.
- Do not allow your baby to crawl around hot stoves, floor heaters, or furnace vents.

Drowning

- Never leave your baby alone in a bath or around containers of water, such as buckets, wading pools, sinks, or open toilets.

Poisoning and Choking

- Never leave small objects in your baby's crawling area.
- Do not give your baby hard pieces of food.
- Store all medicines and household cleaning products up and out of his reach.
- Use safety latches on drawers and cupboards that contain objects that might be dangerous to him.

Reprinted with permission from: Shelov, S.P. & Hannemann, R.E. (1991). Caring For Your Baby and Child: Birth to Age Five. New York: Bantam Books, p. 247.

CHILD DEVELOPMENT SCENARIOS

How can the PSS help in the following situations?

1. Geena's baby is 8 months old. She keeps trying to help him walk but he just wants to get down and crawl. She is getting frustrated.

2. LaToya's baby is 12 months old. He loves getting all over the house and does this by rolling. She is worried because she sees other babies crawling and cruising.

3. Deanna is annoyed that her 9 month old baby will not hold his bottle throughout the whole feeding. She wants to do other things while he is drinking his bottle. She asks you for advice.

4. Carol is disappointed that her 10 month old doesn't seem to like music. She likes when her mom dances with her but doesn't pay any attention to the music when it is turned on.

5. Tonya puts Jalen, who is 9 months old, in an empty playpen and walks out of the room. She doesn't understand why he cries all the time.

PIP TRAINING
SITE VISIT OBSERVATION

Name of Setting: Age of Child Observing:

Number of Children: Number of Adults:

1. Observe the environment carefully; look at facilities, materials and personnel. In what way(s) is it appropriate for:
    a. Children's play and interaction:
    b. Daily caretaking:
    c. Safety:

Are there ways it is inappropriate?

a. Children's play and interaction:
b. Daily caretaking:
c. Safety:

2. Describe the personality or interaction style of the baby you observe.

3. What do the caregivers do to encourage the baby's development?

4. For the specific baby you observe, what skills do you see s/he has?
    a. Motor:
    b. Cognitive:
    c. Emotional:
    d. Social:
    e. Communication:

5. Do you notice that the child has preferences?

	What the Child Prefers	How Do You Know
For Toys or People?		
For Specific Toys?		

6. Do you have any concerns about the baby? What are they? Why are you concerned?

LANGUAGE DEVELOPMENT

In order to help children learn to talk, we need to talk to them long before they can answer. Children learn to understand words (receptive language) before they know how to say these words (expressive language).

How do we facilitate young children's language?

Always try to follow the children's lead. Get involved with what they are already doing.

1. **Repeat** young infant's coos and babbles. Encourage them to continue to verbalize.

2. **Describe** what the child is seeing, hearing or doing as she is doing it.

   - "You are making a big mud pie!"

   - "You put the branch in the bucket."

3. **Label** objects for the child. You don't need to create special times for this. It will be much more meaningful for the child if you label the objects the child is already playing with, touching, or looking at.

   - "That's a truck. A big truck."

   - "The truck is full of sand."

4. **Describe** what you are doing **with the child**. Prepare children for what will happen. **Always** tell infants what you are going to do with them.

   - "Your diaper looks wet. Let's change your diaper."
     (Then take baby to the changing table.)

   - "That shirt is very wet. I need to change it."

Reprinted with permission from: Weitzberg, B. (1992). *"Exploring the World of Infants and Toddlers: A Training Manual About Infants, Toddlers, and their Parents,"* Baltimore, Maryland: Friends of the Family, Inc., pp. 125-127.

5. **Describe** what you are doing as the child watches.

    - "I'm pouring the juice into the cup."

    - "I'm going to call up Grandma on the telephone."

6. **Expand** on what the toddler says.

    - If the child says, "Ba", you can say, "You want your bottle?"
    - If the child says, "Beh", you can say, "That's right, that is a bear. A brown bear."

7. When the toddler starts using short, two-word sentences **expand on them**.

    - When the child says, "Daddy come," you can say, "You want your daddy to come?"
    - When the child says, "Pick up," you might say, "You want me to pick you up?"

8. **Read to your baby and toddler.**

    - Instill a love of books and reading in young children by choosing developmentally appropriate books and making the reading experience warm, intimate, and close.
    - Begin with simple picture books that depict objects, people, and situations that are concrete and real to the infant. (Little Johnny taking a bath loves to hear about little Johnny taking a bath.)
    - Continue first story books that have simple plots with a predictable order, rhythmic and repetitive language, and characters and situations with which toddlers can identify.

What About Correcting Children's Speech?

It is natural for children to make many mistakes when they began to talk. They may mispronounce words or use them incorrectly.

When we use **direct correction** we stop the conversation and correct the child. In **indirect correction** we repeat what the child said correctly without drawing attention to his mistake.

Take for example a child who says, "Mommy, I 'plashing."

In indirect correction you would then say, "Yes, you are splashing in the water!" Contrast this to direct correction in which you may say, "No, say splashing."

Which do you think makes the child feel better?
Which statement might confuse the child?

Did the adult mean: "No, you are not splashing" or "No, not 'plashing, you say splashing".

EVALUATION OF TEACHING MATERIALS

WERE THE MATERIALS EASY TO UNDERSTAND?

WHICH ONES DID YOU LIKE BEST AND WHY?

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

POST-UNIT TEST

1. List some of the major developmental milestones that occur in the 8-12 month stage. Cover all areas of development.

2. Describe one way in each area that parents can assist their child's development.

   Motor

   Cognition

   Language

3. Define what "Separation Anxiety" is and how you will know this is happening.

4. How can a PSS help parents deal with separation anxiety?

5. List three observations of development that would be of concern at this age.

   a.

   b.

   c.

6. What advice about safety would you give a mother of a 10-12 month old?

7. Please number the following stages of language development as they occur in a child's development.

   ____Imitation ____Cooing ____First Words ____Crying

   ____Words ____Babbling

8. Why might a child between 8 and 12 months need to be disciplined? What are some of the strategies that would be appropriate to use?

POST-UNIT EVALUATION

UNIT COVERED: ______

DATE________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

BEST COPY AVAILABLE

Unit 19
CHILD GROWTH AND DEVELOPMENT: ONE TO TWO YEARS

In this unit, participants will review developmental milestones from 1 to 2 years of age, learn how to help parents understand stages of development and interpret baby-toddler behavior, share activities that both parents and their babies or toddlers will enjoy, recognizing possible problems in babies or toddlers growth and development and identify available resources for babies/toddlers and parenting families.

Objectives

By the end of this unit, participants will be able to:

- List the major developmental milestones during the one to two year period.
- Describe and demonstrate ways in which parents can support their child's development at various stages, particularly through the use of play.
- Describe how the developmental milestones in this period require changes in parenting approaches, especially in the social-emotional area.
- Demonstrate how to talk to mothers about ways to play and interact with their children during this stage.
- Demonstrate an understanding of the continuity of development, of how developmental milestones at this stage relate to those in the stages before and after this stage.
- Describe how differences in temperament and the "fit" between parent and child can affect parent-child interactions at this stage.
- List three possible developmental problems to which Parenting Support Specialists should be alert during this stage.
- Demonstrate developmentally appropriate ways to support parents in supporting their child's development, especially in the social-emotional area.

Time

35 hours

Outline

A. Developmental Milestones
B. Language Developments
C. Social and Emotional Development
D. Developmental Alerts
E. Site Visits
F. Providing Guidance and Support
G. Summary and Review

Materials

- Books on toddlers such as:
  - Shelov, S.P. & Hanneman, R.E. (1991). American Academy of Pediatrics Caring for Your Baby and Child: Birth to Age Five. N.Y.: Bantam Books.
  - Leach, P. (1990). Your Baby and Child from Birth to Age Five. N.Y.: Knopf.
  - Brazelton, T.B. (1974). Toddlers and Parents: A Declaration of Independence. N.Y.: Dell Publishing.
  - Brazelton, T.B. (1992). Touchpoints. N.Y.: Addison-Wesley.
  - Greenspan, S. and Greenspan, N. (1985). First Feelings. N.Y.: Penguin Books.
  - Galensky, E. (1981). Between Generations: The Stages of Parenthood. N.Y.: Berkeley Books.
  - Parks, S. (1988). HELP... at Home. Palo Alto, CA: Vort Corporation.
- Videotapes of parent-child interaction in play (optional)
- Video: *Flexible, Feisty and Fearful, The Different Temperaments of Infants and Toddlers*, CA State Department of Education, P.O. Box 944272, Sacramento, CA 94244-2720
- Video: *Talking is Sharing*, Dr. Rae Banegan, 7 Christine Street, Palmer, MA 01069
- Weitzberg, B. (1992). Exploring the World of Infants and Toddlers: A Training Manual about Infants, Toddlers and their Parents. Baltimore, MD: Friends of the Family, Inc.
- Pamphlet, "How Does Your Child Hear and Talk?", American Speech and Hearing Foundation, 10801 Rockville Pike, Rockville, Maryland 20852
- Timeline posted on wall with Developmental Tasks written on post-it notes to one year, extended to two years
- Developmental Milestones **(Handout #1)**
- Observation Guide: Developmental Milestones and Behaviors **(Handout #2)**
- Language Development **(Handout #3)**
- Developmental Health Watch **(Handout #4)**
- Safety Check and Immunization Alert **(Handout #5)**
- Toilet Mastery **(Handout #6)**
- Working with Toddlers **(Handout #7)**
- Site Visit Observation Form **(Handout #8)**
- Role Play Feedback **(Overhead #1)**
- Post-Unit Evaluation
- Blackboard and chalk or newsprint, markers and tape.

Advance Preparation:

- Review *Caring for Your Baby and Young Child*, Chapter 10, "The Second Year", pp. 250-284.
- Review *Exploring the World of Infants and Toddlers* , pp. 93-94, 96-97.
- Review *First Feelings*.
- Review *Between Generations*, The Stages of Parenthood: The Authority Stage.
- Review other books on toddlers development.
- Review HELP information, pp. 403-412, 428-430.
- Review all handouts and use them to supplement information from other sources for mini-lectures.

- Review the videos *"Flexible, Feisty and Fearful"*, *"Talking and Sharing"* and any others on parent-infant interaction .
- Make sufficient copies of any handouts to be used.
- Bring a copy of S.P. Shelov and R.E. Hannemann's *American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5.*
- Bring books, curriculum guides, kits and other materials available to PSSs to use with mothers and children.

A. DEVELOPMENTAL MILESTONES (7 hours)

Rationale: Give the PSSs a framework into which they can fit the detailed information which is to follow by introducing the toddler, one to two years, based on information in **Caring for Your Baby and Young Child**, pp. 249-251 (15 minutes).

- Increasingly mobile, walking
- less dependent on you
- testing the limits--his and yours
- need for reassurance and security
- understands much, speaks a little

Procedure: **Ask participants.** *What do you think are the biggest problems parents face during the second year?* Write these on a flipchart. *What are some ways they usually handle these problems?* Process the discussion by writing responses next to the problems listed. What do you think are the best ways to handle problems with toddlers? Discuss.

1. APPEARANCES

Rationale: Mothers will continue to notice changes in their baby's physical appearance during the second year. PSSs can help mothers know what to expect (15 minutes).

Procedure: **Mini-lecture.** Growth slows by end of first year. During the second year, the child will gain a total of only 3 to 5 pounds.

At 15 months:	Average 22-23 pounds, 31 inches
By 2 years:	Average 27-28 pounds, 34 inches About 90% of adult head size Develop muscles, lose baby fat, longer arms and legs, feet point forward, more angular face and defined jawline.

2. SKILL AREAS (6.5 hours)

Procedure: 1. **Timeline Activity.** Review the timeline posted on the wall to get a clear picture of the child at one year of age. Ask the trainees to write characteristics of the two-year old child on post-it notes and place them under the timeline under "2 Year Old".

2. **Mini-lecture.** (6 hours) Review the developmental milestones in the following areas: Movement, Hand and Finger Skills, Language, Cognitive and Social Development presented in **Caring for Your Baby and Child**, pp. 251-262 and other developmental information. Note that social and emotional development will be discussed in greater detail in a later section of this training

unit. Give each participant a copy of the *Developmental Milestone Charts* **(Handout #1)**.

3. Live Observation and Discussion. Number 1: Have a mother bring her child of 12 to 14 months to the training and play and interact with him as the trainees observe. Do this through an observation window if one is available. Videotape this interaction so that trainees may review it on their own to reinforce learning.

Divide the trainees into small groups of 2 or 3 and ask them to write behaviors they observed in each of the developmental areas using the *Observation Guide: Developmental Milestones and Behaviors* **(Handout #2)**. Give them 15-20 minutes to complete the worksheet and then lead a discussion of the whole group. Process the discussion on flip charts with one page for each development area. Connect present skills to development during the preceding months.

Number 2: Repeat the observation and discussion with an 18-month old child and his mother.

Number 2: Repeat the observation and discussion with a 2-year old child and his mother.

4. Activity: Review of Timeline. Ask participants to look at the placement of the developmental tasks on the timeline at 2 years. Based on the lectures, discussions and demonstrations, ask them to move any of the milestones back to the 18-month stage or at other points during the second year as they see them developing before 2 years. Discuss any differences of opinion stressing the individuality of each child and the range in which skills normally develop.

B. LANGUAGE DEVELOPMENT (7 hours)

Rationale: Language development is an important developmental accomplishment of the child during the second year of life. The language environment provided by the parent and other adults is critical to the child's developing communication. This section discusses receptive and expressive language development during the second year. Importantly, it ties the obvious skill of the child saying words and beginning to speak in sentences to the development of communication and the communicative environment during the first year of life.

Procedure: **1. Mini-lecture.** Review the developmental milestones for the first year and introduce them in more detail for the second year using the *Language Development Chart* **(Handout #3)**.

Based on the information in *Caring for your Infant and Young Child* and other books on child development, review the definition of receptive and expressive language, discuss progression of speech and language development, and discuss and demonstrate ways parents can facilitate language development. Emphasize the importance of a balanced, responsive interaction between parent and child at each stage of development. Ask the trainees to give examples of how parents can encourage communication at each stage.

2. **Demonstration.** Demonstrate the techniques of self-talk and parallel talk by demonstration by two trainers using the "Two Men and a Baby" technique. One trainer should be the adult playing with the child who is the other trainer. The child should speak her thoughts as the adult plays, but does not speak. For example, as they play with a ball, the child says, "I wonder what that is? Look at that--what is it doing?" Next, the same play interaction is repeated and the adult names the objects and actions involved and the child repeats words or word combinations. For example, the adult says, "Ball. Ball. Roll the ball. You got it-you got the ball. Roll it-roll the ball." And the child says "Ball. Ball!"

3. **Video.** Show the video "Talking is Sharing". Process the video by discussing ways parents/adults facilitated communication, including turn-taking, self talk and parallel talk. Ask trainees what kinds of things might make it difficult for parents to use these techniques.

4. **Video Exercise (optional).** Show videotapes of parent-infant play situations with the sound turned off. Ask a trainee to demonstrate the use of self talk and parallel talk they would use in the play situation. Move from one trainee to another asking each to "talk over" the action until each has had an opportunity to participate.

C. SOCIAL AND EMOTIONAL DEVELOPMENT (6 hours)

Rationale: During the second year, the child works to establish himself as an independent person. He recognizes that he is separate from his mother, he has "a mind of his own" and tries hard to get his own way. He is possessive and finds it difficult to share. He often is aggressive with his parents and with other children. All of these characteristics make it difficult for parents to interact with the child in a positive way. Questions about tantrums and discipline are frequent during this period. The PSS can help the parent prepare for this stage which will come when she no longer is there to help and support the parent. This information is also useful for supporting the parent in her interactions with older siblings.

Procedure: 1. **Mini-lecture**. Discuss the emotional development of the child during the second year using *Caring for Your Infant and Young Child*, Chapter 10, pp. 263-264 Greenspan's *First Feelings* and other developmental information. Focus specifically on the period of the second year, but discuss both the periods before and after. Point out the tasks of the child and of the parent at this stage (reference Galinsky's Chapter 3, The Authority Stage).

Ask trainees to share their experiences of dealing with the issues at this stage with their own children and/or with children in their family or work situations.

2. Video. Introduce the concept of temperament by showing the videotape, *Flexible, Feisty and Fearful.* Encourage trainees to personalize the information by asking if they have known a child who is feisty? fearful? flexible? Discuss the impact temperament can have on parenting. What might parents have to do differently depending on their child's temperament?

D. DEVELOPMENTAL ALERTS (1 hour)

Procedure: **1. Discussion.** Remind participants that each baby is an individual and will develop at his own rate. However, there may be times when the PSS is concerned about a baby during this time of one to two years. Ask participants to tell you what they would consider warning signs for medical or developmental problems during this period. Process their answers by writing them on the flip chart.

2. Activity. Refer each participant to their copy of the *Developmental Health Watch* **(Handout #4)** from p. 264 of *Caring for Your Baby and Child.* Ask them to match any warning signs that were listed by the trainees to the ones included on the chart.

Discuss each of the developmental health watch points. Answer any questions they have about what is normal or typical development and when they should be concerned. Be sure to include health and emotional issues in discussing why a child's development might be delayed at this age. Briefly mention the following and note that these are discussed more fully in other sections of the training: inadequate nutrition, chaotic or violent environment, child abuse, and prenatal exposure to drugs or alcohol.

3. Activity. Safety and Discipline. Refer each participant to their copy of *Safety Check and Immunization* **(Handout #5)**. Discuss each item. Ask participants why they think it might be difficult for the mothers with whom they are working to follow these safety rules? How might they encourage them to follow the rules? Ask them to be specific.

4. Review Handout #6, Toilet Mastery. Discuss why this might be difficult with the clients with whom you will be working. Be sure to address cultural expectations.

E. SITE VISITS (7 hours)

Procedure: 1. **Review "Working with Toddlers (Handout #7)** to focus participants on appropriate interaction with toddlers. Participants should visit day care centers, day care homes, or other programs to observe typically-developing infants from 12 to 24 months old. Participants should focus on developmental milestones, social/emotional behavior, and appropriate toys and play interactions. Participants should fill out Site Visit Observation Form **(Handout #8)** after/during their observation.

2. Participants may all visit one center or go to more than one center. A member of the Pride in Parenting training staff should be present for part of the time or should ensure that on-site staff are able to guide trainees in observation and interaction with infants.

3. After the visits, ask each participant to discuss the child(ren) she observed and the developmental milestones she observed. How did the parent/caregiver facilitate the child's development? Did they observe any developmental alerts. What else did they observe that they considered important?

F. PROVIDING GUIDANCE AND SUPPORT (7 hours)

Rationale: In this part of the training, participants will examine ways to interact with infants and with parents around child development issues. As pointed out in the Resource Mothers training, it is important for PSSs to learn how to support and encourage without undermining the self-esteem of the parents.

Procedure: 1. **Review of Development Milestones.** Briefly review the milestones from one to two years by writing each developmental area (Movement, Language, Cognitive, Social/Emotional) on a flip chart and asking the participants what they remember the baby is doing in this area during the period. Complete each area.

2. Role Play Scenarios. Ask each participant to select a partner or assign partners. One will play the PSS and the other the mother. Then they will change. Have each pair draw a card from your hand with a Child Development Scenario written on it **(Handout #9)**. Remind the trainees that like the child you get in real life, the Scenario you get is "luck of the draw". It may or may not match with your own temperament or with the type of child behavior you are comfortable with.

Give each team 15 to 20 minutes to jot down responses to the question asked at the end of the scenario.

Bring everyone back together and ask each team to play out its scenario with the mother introducing the scenario to the PSS. The PSS should talk to the mother as she would on a home visit. Following each scenario, process the activity by asking the participants doing the role play, then the rest of the participants the **questions on role play/feedback (Overhead #1)**.
After all pairs have had an opportunity to role play the scenarios, take a break, then repeat the entire role play scenarios activity with the partners switching roles.

G. SUMMARY AND REVIEW (15 minutes)

Procedure: 1. Rephrase the objectives of this unit as questions. Ask volunteers to answer each question.

2. Ask participants whether the learning objectives they stated at the beginning of the unit were met. What information do they feel they still need on growth and development of the one to two year old child.

3. Distribute the post-unit evaluation forms.

4. Distribute the post-unit test.

DEVELOPMENTAL MILESTONES

One to Two Years
By the End of This Period

Movement

- Walks well and begins to run
- Walks up and down stairs holding on
- Climbs into and out of an adult chair
- Throws ball overhand
- Pulls toys behind him while walking

Cognitive

- Imitates scribbling
- Works puzzles of 4-5 pieces
- Activates simple toys (jack-in-the-box, musical box)
- Combines actions in play (puts person in car and pushes car)
- Engages in pretend play (feeding doll, fixing car)

Language

- Looks at pictures when someone talks about them
- Follows two directions at one time
- Uses words accompanied by gestures to communicate
- Asks for "more"
- Refers to self by name
- Answers questions
- Combines words into simple sentences (more juice, Daddy bye-bye)

Emotional

- Has a will of his own and a need for independence
- Episodes of separation anxiety increase toward midyear, then fade
- Plays alone in a group, but watches others
- Shows intense positive and negative reactions
- Becomes easily frustrated
- Pays attention to other children
- Imitates behavior of adults and especially older children

OBSERVATION GUIDE: DEVELOPMENTAL MILESTONES AND BEHAVIORS

Movement

Language: Receptive

Language: Expressive

Cognition

Social/Emotional

SPEECH AND LANGUAGE DEVELOPMENT: One to Two Years

Expressive Language Development

12 to 18 Months

Has a vocabulary of 3 to 20 words (e.g., bye, more, no, juice)
Communicates with gestures, pointing and vocalizations
Jabbers or jargons, sounding like adult speech
Answers questions, such as "What's that?"
Imitates new words

18 to 24 Months

Has a vocabulary of 50 to 200 words
Uses words more than gestures to communicate
Combines words into simple phrases (go bye-bye, Daddy shoe)
Imitates sounds of animals, car, airplanes, etc.
Declares ownership by using "mine"
Calls self by name
Frequently uses "no"

Receptive Language Development

12 to 18 Months

Knows the name of familiar objects, people and actions
Points to a few body parts when named
Looks for and finds familiar objects when requested
Likes to listen to music and rhymes
Points to pictures in a book
Follows familiar one-step commands (Get your bear)

18 to 24 Months

Knows the name of many objects, people and actions
Understands the differences in personal pronouns (me, you)
Understands the prepositions "in" and "on"
Follows two or three related commands with the same object
Understands complex sentences (When Daddy comes home, you can go for a walk)

DEVELOPMENTAL HEALTH WATCH

Because each child develops at his own particular pace, it's impossible to tell exactly when yours will perfect a given skill. The developmental milestones listed in this book will give you a general idea of the changes you can expect as your child gets older, but don't be alarmed if he takes a slightly different course. Alert your pediatrician, however, if he displays any of the following signs of possible developmental delay for this age range.

- Cannot walk by eighteen months
- Fails to develop a mature heel-toe walking pattern after several months of walking, or walks exclusively on his toes
- Does not speak at least fifteen words by eighteen months
- Does not use two-word sentences by age two
- By fifteen months does not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
- Does not imitate actions or words by the end of this period
- Does not follow simple instructions by age two
- Cannot push a wheeled toy by age two

Source: Shelov, S.P. & Hannemann, R.E. (1991). Caring For Your Baby and Child: Birth to Age Five. New York: Bantam Books. pp. 264 and 283.

SAFETY CHECK

Sleeping
- Keep crib mattress at lowest setting
- Keep the crib free of any objects that your toddler could stack and climb on to get out
- If your toddler can climb out of his crib, move him to a low bed
- Keep the crib away from all drapery and electrical cords
- Be sure all cradle gyms and hanging toys have been removed from the crib

Toys
- Do not give your toddler any toy that has to be plugged into an electrical outlet
- Do not give him a motorized riding toy

Water
- Never leave your toddler, *even for a few seconds*, in or near any body of water without supervision. This includes a bathtub, wading pool, swimming pool, fish pond, whirlpool, hot tub, lake, or ocean

Auto
- Never let your toddler climb out of his car seat while the car is moving
- Never leave him alone in the car, even if it is locked and in your driveway

Home
- Protect any open windows with screens or barriers that your toddler cannot possibly push out
- Make sure all electrical outlets have caps on them and all cabinets that contain cleaning fluids or other dangerous items have safety locks on them
- If you have guns (which are not recommended to be kept in a house occupied by children), keep them unloaded and locked up out of sight. Store ammunition in a separate location

Outdoors
- Hold on to your toddler whenever you're near traffic
- Set up fences or other barriers to make sure he stays within his outside play area and away from the street, pools, and other hazards
- Make sure there is grass, sand, wood chips, or other soft surfaces under outdoor play equipment

Source: Shelov, S.P. & Hannemann, R.E. (1991). Caring For Your Baby and Child: Birth to Age Five. New York: Bantam Books. p. 283.

IMMUNIZATION ALERT

At fifteen months, your toddler should receive:
- Measles, mumps, rubella vaccine (MMR)
- Vaccine against *Haemophilus influenzae* bacteria (HBCV). (This may cause a slight fever and some soreness where it's injected.) The vaccine helps prevent meningitis, pneumonia, and joint infection caused by *Haemophilus influenzae* bacteria.

And at eighteen or nineteen months:
- The fourth dose of the DTP vaccine
- The third dose of oral polio vaccine

Source: Shelov, S.P. & Hannemann, R.E. (1991). Caring For Your Baby and Child: Birth to Age Five. New York: Bantam Books. p. 283.

TOILET MASTERY

Mastering toileting is like any other learning. It takes time, practice, and considerable patience from parents. Setbacks are normal.

Help parents by comparing toilet mastery (or toilet learning) to walking or any other learning. Would anyone expect a baby to walk before his muscles are strong enough to allow him to sit up and stand?

Similarly, children need to be **READY** to learn to use a toilet.

Before parents begin toilet teaching they need to ask themselves:

- Can my child walk? Does he have good muscle control?
- Is my child almost two years old?
- Does my child have episodes where his/her diaper stays dry for long periods?
- When wet or soiled, does my child seem uncomfortable?
- Is my child able to tell me or let me know when she needs to use the potty?
- Can my child follow simple directions?
- Does my child show any interest in using the toilet or imitating his parents or older brothers and sisters?

PREPARE THE CHILD

1. Teach words for body parts and functions.
2. Name and point out wet and dry diapers.
3. Talk about how good it feels to be dry.
4. Choose a good time. The arrival of a new baby, moving homes, or starting day care can be very stressful for a child. Wait a few months till things settle down.
5. Give the child a low potty seat. She/he will feel safer and be able to get on and off as she/he pleases. She/he can then be in charge of putting the BM's and urine in the toilet, and flushing.
6. Tell the child what you expect him/her to do.
7. Praise attempts. Try to ignore accidents.

Remember that children first develop control during the day. It may be much later before the child has the ability to stay dry through the night.

Source: Weitzberg, B. (1992). Exploring the World of Infants and Toddlers, A Training Manual About Infants, Toddlers and Their Parents. Baltimore, Maryland: Friends of the Family.

WORKING WITH TODDLERS

Some guidelines for working with toddlers are:

1. Realize that toddlers want to be "grown up". Let them help around the house or classroom. Toddlers can dust, put away groceries, and help with simple food preparation.

2. Toddlers love routines and often hate when their routines are changed. Try to develop simple routines to help them with difficult times such as going to bed, getting up in the morning, and getting dressed. Routines are also very helpful in childcare (i.e., clean up song and five-minute warning before clean up time).

3. Allow toddlers to make simple choices. Providing choices can help avoid power struggles. For example, rather than telling toddlers to get dressed, give a choice between two options. (Would you like your red shirt or your blue one?)

4. Don't give toddlers choices if you don't mean it. For example, don't ask them if they want to go to bed if they have no choice in the matter.

5. Don't let toddlers fool you into thinking they are more mentally and socially mature than they really are. Toddlers:
   - are focused on themselves (egocentric). Don't expect toddlers to share easily. In childcare it is often better to have duplicates of favorite toys over a variety (three red firetrucks instead of three different vehicles).
   - have unpredictable attention spans. Don't expect them to be able to wait for long periods of time.
   - are rigid and conservative. Slowly introduce new things or changes in their routines. Expect them to resist change.

6. Toddlers often respond better to physical rather than verbal guidance, such as, guiding them gently with your hand, picking them up, or restraining them.

7. Whenever possible, allow toddlers to be independent. Dress them in clothes that they can easily put on or take off. Install low hooks to enable them to hang up their coats by themselves.

8. Limit your requests to as few as possible. Choose your fights carefully. Decide what the important issues are and stick to them. Other fights are probably not worth fighting.

9. Ignore as much of the negative behavior as possible.

10. Try to allow tantrums to run their course, and do your best to say calm.

Source: Weitzberg, B. (1992). Exploring the World of Infants and Toddlers, A Training Manual About Infants, Toddlers and Their Parents. Baltimore, Maryland: Friends of the Family.

PIP TRAINING
SITE VISIT OBSERVATION

Name of Setting:

Age of Child Observing:

Number of Children:

Number of Adults:

---

1. Observe the environment carefully; look at facilities, materials and personnel. In what way(s) is it appropriate for:

   a. Children's play and interaction:

   b. Daily caretaking:

   c. Safety:

Are there ways it is inappropriate?

   a. Children's play and interaction:

   b. Daily caretaking:

   c. Safety:

2. Describe the personality or interaction style of the baby you observe.

3. What do the caregivers do to encourage the baby's development?

4. For the specific baby you observe, what skills do you see s/he has?

   a. Motor:

   b. Cognitive:

   c. Emotional:

   d. Social:

   e. Communication:

5. Do you notice that the child has preferences?

	What the Child Prefers	**How Do You Know**
For Toys or People?		
For Specific Toys?		

6. Do you have any concerns about the baby? What are they? Why are you concerned?

CHILD DEVELOPMENT SCENARIOS

How can the PSS help in the following situations?

1. Anya is frustrated with her 18 month old because all she seems to want to do is run around the apartment. She will not stay still in a seat or happily in a play pen.

2. Nikesha gets angry at her 2 year daughter for always pulling the pots and pans out to play with. She keeps giving her stuffed animals and rattles to try to get her away from the pots and pans.

3. Tracy feels like she is "going crazy" because Jalen, who is 20 months old, always wants to be right near her. She thinks there is something wrong with him and doesn't know what to do.

4. Brenda's daughter Jamia is 22 months old. When Brenda takes her to church playgroup, which has children from 2 - 4 years, Jamia stands and watches the other children or plays alone and does not play with others. Brenda keeps trying to get her to play with the children but is not having any success.

5. Trena is embarrassed by Antoine's screams when they are in the supermarket. He seems happy but makes very loud sounds. She tries to cover his mouth but this only makes him upset.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

POST-UNIT TEST

1. List two ways to support autonomy or the growing sense of self in the toddler.

   a. ______________________________

   b. ______________________________

2. Check three positive means of setting limits for the exploring toddler.

______ a. Stop the behavior by any means such as holding or spanking.

______ b. Give a brief explanation for stopping the behavior.

______ c. Remove the child from danger.

______ d. Correct and reprimand strongly.

______ e. Isolate the child.

______ f. Redirect with another toy or activity.

3. From the description of a toddler's behavior listed below, write the following in columns one and two:

   a. Describe a reason for the behavior.
   b. Describe an appropriate adult response that will support the child.

   I. James grabs toy trains from Marcus and insists on putting them where he wants them.

a. Reason	b. Appropriate Response
______________________	______________________
______________________	______________________

   II. Kisha pokes angrily at the new baby in the family.

a. Reason	b. Appropriate Response
______________________	______________________
______________________	______________________

4. Name three toys that encourage development in the toddler.

   a. ______________________________

   b. ______________________________

   c. ______________________________

5. List two things to consider when deciding if a child is ready to use the toilet.

   a. ______________________________

   b. ______________________________

POST-UNIT EVALUATION

UNIT COVERED: _____

DATE_______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

Unit 20
CHILDREN IN VIOLENT CIRCUMSTANCES

The purpose of this unit is to provide the Parenting Support Specialists (PSS) with an overview of violence and its impact on the functioning of society, the family, and the development of the children. Included will be a discussion of the societal and individual factors that contribute to violence and abuse. The legal definition of abuse and neglect in the District of Columbia, the requirements for reporting, penalties for not reporting, and designated personnel for receiving reports of abuse and neglect in the District will be discussed. Procedures for the reporting of suspected abuse and neglect by the PSS will be outlined.

Objectives

By the end of this unit, the participants will be able to:

- Define interpersonal violence.
- List five cultural factors that contribute to high violence levels.
- List three cultural factors that contribute to low violence levels.
- Describe some of the effects of attempting to parent within a chronic, highly violent environment.
- Describe the impact of living in a chronically violent environment on children's development.
- List five characteristics of the high violence/abusive parent.
- List five antecedents of violent behavior in children.
- Define physical, verbal and sexual abuse, and neglect.
- Describe the typical patterns found in an abusive family.
- Describe five typical effects of physical abuse on children's behavior and development.
- List five symptoms of sexual abuse in children.
- Describe five factors that decrease the probability of the occurrence of abuse to children.
- List five strategies to prevent violence and abuse within the family.

Time

6 1/4 Hours

Outline

A. Definition/Overview of Violence: Facts and Figures.
B. Cultural Attitudes/Characteristics Related to Violence.
C. Familial Characteristics Related to Violence.
D. Abuse/Neglect Issues.
E. Violence Prevention Strategies.
F. Effective Violence Intervention Programs.
G. Summary.

Materials

- Transparencies/Handouts:
    - Statistics on Violence **(Handout #1)**
    - Cultural Factors that Influence High and Low Levels of Violence **(Handout #2)**
    - Effects of Chronic Violence on Parents and Children **(Handout #3)**
    - Familial Characteristics Related to Violence **(Handout #4)**
    - Characteristics of Abusive/Neglectful Behavior in Parents **(Handout #5)**
    - Effect of Abuse/Neglect on Children's Behavior & Development **(Handout #6)**
    - Pride in Parenting, Abuse and Neglect Guidelines **(Handout #7)**
- D.C. Government Pamphlet on Child Abuse Reporting Responsibilities (copies for all participants)
- American Psychological Association. (1993) Violence and youth: Psychology's response. Vol. I: Summary report of the American Psychological Association Commission on violence and youth. Washington DC: American Psychological Association.
- Conway, L.P. & Hansen, D.J. Social Behavior of Physically Abused and Neglected Children. Clinical Psychology Review. Vol.19, pps. 627-652.
- Osofsky, J. D. & Fenichel, E. (Eds.) The Zero to Three Study Group on Violence. Caring for Infants and Toddlers in Violent Environments: Hurt Healing and Hope. Arlington VA: NCCIP.
- Post Unit Test
- Post-Unit Evaluation
- Blackboard and chalk, or easel with paper and markers
- TV, VCR, tripod, video camera, video tapes

Advance Preparation

- If needed, arrange for an expert in abuse and neglect and local reporting procedures to speak to group
- Review above listed articles
- Review handouts and make needed transparencies and sufficient number of copies of handouts
- Set up and test video equipment; setup camera to record session

A. DEFINITION/OVERVIEW OF VIOLENCE: FACTS AND FIGURES (1 hour)

Rationale: The purpose of this training session is to give the PSS a picture of the scope of violence and its effect on the family environment.

Procedure: **1.** Review definition of 'violence' as follows. Discuss examples of the general situations mentioned. ***Definition:*** "Violence refers to immediate or chronic situations that result in injury to the psychological, social or physical well-being of individuals or groups. Interpersonal violence is behavior by persons against persons that threatens, attempts or completes intentional inflection of physical or psychological harm." APA Commission on Violence and Youth.

2. Participant discussion. Begin by asking the trainees some of the following questions. Why has there been such a dramatic increase in the amount of violence among the young in our society? How does violence within the community affect the family? How does the level of violence within the community affect the parents' ability to take care of their children? How does violence within the community affect the children? How can parents help their children to be safe in a high violence area? How much violence should a society tolerate within the family without sanctions (i.e. between partners, between parent and child)?

3. Summarize the Discussion. Use the transparency of **Handout #1** and have participants react to the statistics. Distribute Handout #1.

B. CULTURAL ATTITUDES/CHARACTERISTICS RELATED TO VIOLENCE (1 hour)

Rationale: In order to understand violence, PSSs must be aware of the factors promoting high violence and their impact.

Procedure: **1.** Make transparency of **Handout #2** on cultural characteristics related to high and low violence societies. Allow the PSS to react to and discuss each point in relation to our society. Distribute Handout #2.

2. Effects of Living in Chronic High Violence Society/Community On: Discuss what participants believe are the effects of living in a high violence society/community on parents & children. Be sure to include the following information.

a. Parents
- Living in a chronically violent environment may affect parents ability to nurture, protect and parent their children effectively.
- Certain parts of the District of Columbia can be considered a chronic, high violence community. Some of the parents that you will see may exhibit these characteristics.

Discussion Question: In what ways can living in a highly violent society change parenting activities? The trainer can list the changes the home visitors pose on the board. These additional effects can be added if the home visitors do not include them.

- Parents may feel hopeless, overwhelmed and powerless to provide a safe environment for and protect their children from ongoing everyday violence,

- If the parent has been traumatized by violence, he or she may be unavailable to nurture and provide security for the child.

- The parents may become hyper-vigilant and overprotect the child, not allowing him or her to grow and develop normally.

- If the parent is stressed and depressed concerning violence, there may be a tendency to be irritable and hostile, particularly in intimate relationships.

b. Children

- The exposure to chronic violence affects young children's view of themselves, the world and their relationships with others around them.

- Sometimes children in chronically violent environments may experience symptoms of post traumatic stress disorder such as sleeping difficulties, nightmares, eating problems, attention problems in school, re-enactment of traumatic events, fearfulness and anxious reactions.

- Older children may resort to carrying guns or other weapons out of fear of violence from their peers.

- Pre-adolescents and adolescents may join gangs for a sense of security.

C. FAMILIAL CHARACTERISTICS RELATED TO VIOLENCE (1 hour)

Rationale: In order to assist parents in positively impacting their parenting, PSSs need to know what may cause violent behavior.

Procedure: **1.** Review information on **Handout # 4** and distribute handout. Discuss each point. Add any comments by participants to the list.

2. First ask participants to identify what causes violent behavior in parents and in children. Make lists.

Causes of Violence in Parents

- Inadequate or harsh parenting delivered to them as children.

- Lack of exposure to role models other than the use of harsh discipline.

- Inadequate problem solving skills, feelings of powerlessness and inadequacy, low self-esteem.

Causes of Violence in Children.

- There may be biological contributions to aggressive or violent behavior in children, i.e. basic temperament and activity level. Birth trauma and other neurological trauma, both prenatally and post-natally may cause subtle brain damage.
- Early family influences may also contribute to violent behavior in children. These influences include: weak or absent nurturing by a primary caretaker; parental rejection of the child; anti-social personality of parent; frequent and harsh physical punishment; lack of parental supervision; the subtle condoning of aggression by the parents; high levels of watching television violence. There is a correlation between the amount of watched violence and acted out violence.

D. ABUSE/NEGLECT ISSUES (2 hours)

Rationale: In high violence situations, there is a high risk of abuse and neglect. Since the PSS may be in these types of environments, it is important for them to have a good understanding of abuse and neglect and to be able to recognize it.

Procedure: **1.** Depending on the expertise of your trainees, you might arrange for an expert in abuse and neglect to speak to the group on the information that follows.

2. Review and discuss the information and specific examples of the terms defined below.

Definitions:

a. *Physical abuse* is intentional injury that is inflicted on the child through methods such as beating, burning, scalding, kicking, throwing, strangling, etc.
b. *Verbal abuse* is often called the hidden abuse because it leaves no visible physical scars, only hidden psychological scars. Verbal abuse consists of name calling, humiliation, demeaning the child and his activities, excessive yelling.
c. *Sexual abuse* is any indication of parents, guardians or caretakers engaging in sexual molestation involving a child or any person engaging in sexual molestation with a child due to the neglect of the parents.
d. *Neglect* is the purposeful withholding of things necessary to the well-being of the child. These things can consist of adequate food, clothing, medication and health care, supervision and nurturing.

3. Review and discuss the following statistics.

a. Severe abuse occurs in only 4% of reported cases.
b Over 1 million cases of child abuse are reported annually in the United States.
c Neglect is more common than abuse.

d. Childhood accidents and some fatal injuries can be traced to parental neglect, yet this may not be reflected in the reporting of the injuries or deaths.

e. There is a negative correlation of abuse with economics, though abuse is seen in all class levels and ethnic groups, there is a greater percentage of abuse seen in the lower socio-economic strata.

4. Discuss characteristics of abusive/neglectual behavior. Distribute **Handout #5**. Have participants give examples that they have observed or experienced. Include all information in **Handout #5**.

5. Discuss what happens to children who are abused. Distribute **Handout #6**. Be sure to include information found in **Handout #6.**

6. Ask participants what factors may help to prevent abuse and neglect. Be sure to review the following information.

- Wanted pregnancy.
- Initial pregnancy occurs after the teen years.
- Increased education.
- Adequate income.
- Social supports.
- One study showed that just having a pediatrician call once a week reduced physical abuse that required emergency room treatment in experiment to 0%, 10% in control group.
- Strong kinship bonds.
- Strong spiritual/religious orientation.
- Strong work orientation.
- High achievement orientation.
- Flexibility of family roles.

7. Arrange for an expert in local reporting procedures to join the group discussion.

Legal Responsibilities for Reporting Suspected Abuse and Neglect.

- Professions required by law to report suspected abuse and neglect: Doctors, nurses, child care workers, teachers, social workers.
- Procedures for reporting.
- Penalties for not reporting.
- Abuse and neglect procedures in the District of Columbia. Distribute this information.
- Procedures for home visitors to use when abuse or neglect is suspected during home visits. Distribute and carefully review **Handout #7**.

E. VIOLENCE PREVENTION/INTERVENTION STRATEGIES (1 hour)

Rationale: When discussing the issues of violence in our society, it is important to address prevention and intervention.

Procedure: 1. Brainstorm with group about strategies to prevent violence. Be sure to cover the following information.

- Criminalizing abusive behavior, whether physical or sexual seems to be effective.
- Prevention is most effective when child sexual abusers are treated as criminals. Family violence tends to be repeated less frequently when the perpetrator is arrested.
- Teach children to say "no" to unwanted touching of their bodies by anybody, including family members.
- Encourage children not to be afraid to tell parent or other trustworthy adult about unwanted advances. The child should not be condemned for coming forward with information.
- Many physically abused children show amazing resilience if they have the social support of another family member or other adult, such as a friend or teacher.
- Two-thirds of abused children take good care of their children if they have good social support. Only 1/3 perpetuate the cycle.
- The adults that seems to fare best are the ones that are openly angry about the abuse and can discuss and describe their experience of abuse. Typically they were abused by only one parent, and not both.

2. Discuss programs that can be used to intervene to decrease violence.

- Eighty percent of parents can be helped by working with them to develop more effective parenting strategies.
- Parent Abuse Hotline.
- Parents Anonymous.
- One of the most important interventions may be adequate medical care for parents, parental health problems often accompany abuse.
- Some of the most effective programs are "Home Visitor" programs for at-risk families which include prenatal and post-natal counseling and continued contact with family

and child in the first few years of life. In a 20-year follow-up of one such program, positive effects could be seen for both the at-risk child and for the mother.

G. SUMMARY AND REVIEW (15 minutes)

Procedure: 1. Rephrase the objectives on the first page of this unit as questions. Ask a volunteer to answer each question.

2. Ask participants whether the learning objectives they stated at the beginning of the unit were met. What information do they feel they still need behavior and discipline.

3. Distribute the post-unit evaluation forms.

4. Distribute the post-unit test.

POST-UNIT TEST

Name ____________ ____________ ____________________

1. List four characteristics of high violence societies.

   A.

   B.

   C.

   D.

2. List three characteristics of low violence societies.

   A.

   B.

   C.

3. List three characteristics of high violence families.

   A.

   B.

   C.

4. List three possible effects on the parenting behavior of persons living in high violence areas.

   A.

   B.

   C.

5. List 3 possible effects living in high violence societies on the personality development of children.

   A.

   B.

   C.

POST-UNIT EVALUATION

UNIT COVERED: _____

DATE________________.

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

STATISTICS ON VIOLENCE

1. Violence among youths 11 to 17 has increased 25% in the last decade (Uniform Crime Statistics, 1992).
2. Physical abuse is the leading cause of death in children less than one year of age (Waller, Baker & Szocka, 1989).
3. Thirty-three percent of all sexual abuse cases involve children under six years of age (Schmitt & Krugman, 1992).
4. Homicide is the 2nd leading cause of death among all 15-24 year olds in the United States of America (National Center for Health Statistics, 1991).
5. In 1991, the homicide rate for African-American males 15-24 years of age was 10 times greater than the rate for 15-24 year old white males (National Center for Health Statistics, 1991).
6. In 1991, 1,383 young children (50% were less than 1 year of age) died from abuse.
7. One out of ten children under age six attending a Boston Pediatric clinic had witnessed a shooting or stabbing, either in their homes or on the street.
8. In a survey of sixth, seventh, eighth and tenth grade students, 30% reported witnessing at least one crime daily.
9. In 1990, 222 children in the United States were killed by handguns. During 1990, only 68 persons of all ages were killed by handguns in Canada.
10. At least 3.3 million children witness parental abuse each year. This includes shootings and stabbings as well as beatings (Jaffe, Wilson & Wolffe, 1988).
11. The rate of penetrating injury caused by violence in the emergency room of the Children's National Medical Center increased 1,740% between the years of 1986 and 1989.
12. Forty to 50% of all American households own a firearm (National Rifle Association).
13. Alcohol is implicated as a factor in over half of all violent attacks in the home.

CULTURAL ATTITUDES/CHARACTERISTICS RELATED TO VIOLENCE

Use transparencies on cultural characteristics related to high and low violence societies. Allow the trainees to react to and discuss each point for a short period.

1. Characteristics of High Violence Societies.

- The cultural or folk heroes demonstrate high levels of violence in their exploits, i.e. Bonnie and Clyde, cowboys, "bad dudes," such as James Bond, the Terminator, etc.
- There is a high level of violent crime in the society. America has the highest murder rate in the world.
- The citizens have a right to bear arms and firearms are easily accessible.
- There is a high level of violence in the entertainment, media, sports and leisure activities of the society. For example, sports such as football and LaCrosse, leisure activities such as hunting, war games. Visual and print media in American society highlight violence. News footage is much bloodier than it was 20-30 years ago. Movies and television have gotten bloodier and more violent in the last few decades to the point that there were congressional hearings last year on the amount of violence in prime time television.
- Children are seen as an economic liability.
- There is a lack of social supports, and no close by extended family. Mother and father, or single mother alone, have almost total responsibility for child rearing.
- Primacy of parent/child relationship and inability of others to interfere.
- High rate of physical discipline. Ninety percent of Americans spank their children and feel that it is called for.
- The play of the children mirrors the violence in the society. War toys and guns are frequent playthings of young children. Video games are extremely violent, prompting congressional hearings this year. Toys R Us and Kaybee Toys will no longer carry realistic looking toy guns.
- In societies where there is chronic poverty and deprivation among minorities or the lowest levels of society, violence levels will be high. One of the side effects of high levels of violence in these strata is family instability and breakdown.
- The society's attitude towards and participation with alcohol and other drugs. Drug use is expensive and drug addicts will commit crimes and violent acts to get money to support their habits. Alcohol and cocaine use, and increasingly heroin use, by parents or caretakers is a root cause of violence against children.

2. Characteristics of Low Violence Societies.

- Children are highly valued and often seen as an economic asset.
- The population tends to be homogeneous.
- The child care is shared by many, not just the mother and father.
- There is a low demand level on the behavior of the children. They are rarely punished before two or three years of age.
- The society provides sanctions against violent behaviors among its members.

EFFECTS OF CHRONIC VIOLENCE ON PARENTS AND CHILDREN

A. Parents

- Living in a chronically violent environment may affect parents ability to nurture, protect and parent their children effectively.
- Certain parts of the District of Columbia can be considered a chronic, high violence community. Some of the parents that you will see may exhibit these characteristics.
- Parents may feel hopeless, overwhelmed and powerless to provide a safe environment for and protect their children from ongoing everyday violence.
- If the parent has been traumatized by violence, he or she may be unavailable to nurture and provide security for the child.
- The parents may become hyper-vigilant and overprotect the child, not allowing him or her to grow and develop normally.
- If the parent is stressed and depressed concerning violence, there may be a tendency to be irritable and hostile, particularly in intimate relationships.

B. Children

- The exposure to chronic violence affects young children's view of themselves, the world and their relationships with others around them.
- Sometimes children in chronically violent environments may experience symptoms of post traumatic stress disorder such as sleeping difficulties, nightmares, eating problems, attention problems in school, re-enactment of traumatic events, fearfulness and anxious reactions.
- Older children may resort to carrying guns or other weapons out of fear of violence from their peers.
- Pre-adolescents and adolescents may join gangs for a sense of security.

FAMILIAL CHARACTERISTICS RELATED TO VIOLENCE

1. Characteristics of high violence/abusing parents.
   - Often have health problems that impair their ability to adequately rear their children.
   - Lack of knowledge concerning developmental capabilities, normal behavior patterns of young children. They may be seen as willful, "He knows what he is doing."
   - Unrealistic expectations of children's behavior.
   - Lack of problem solving skills, may typically resort to aggression to solve problems.
   - Inability to read and take cues from baby concerning its needs, fear of "spoiling" child.
   - May have mental illness.
   - High levels of stress within the home due to economic difficulties, lack of adequate coping skills, family crisis.
   - May have cocaine, heroin or alcohol addiction.
   - Typically it was the mother who abused the children with no or passive male present. Now social workers are seeing more males as agents of child abuse, violence, and sexual abuse. Part of this increase may be due to more reporting of child abuse.
2. Causes of Violence in Parents.
   - Inadequate or harsh parenting delivered to them as children.
   - Lack of exposure to role models other than the use of harsh discipline.
   - Inadequate problem solving skills, feelings of powerlessness and inadequacy, low self-esteem.
3. Causes of Violence in Children.
   - There may be biological contributions to aggressive or violent behavior in children, i.e. basic temperament and activity level. Birth trauma and other neurological trauma, both prenatally and post-natally may cause subtle brain damage.
   - Early family influences may also contribute to violent behavior in children. These influences include: weak or absent nurturing by a primary caretaker; parental rejection of the child; anti-social personality of parent; frequent and harsh physical punishment; lack of parental supervision; the subtle condoning of aggression by the parents; high levels of watching television violence. There is a correlation between the amount of watched violence and acted out violence.

CHARACTERISTICS OF ABUSIVE/NEGLECTFUL BEHAVIOR IN PARENTS

1. Typical Profile of Abusing Family.

   - Patterns of physical violence between spouses.
   - More disorganized, chaotic households (those that do not stress the importance of regular predictable schedules and routines such as meal times, early bedtimes, etc.)
   - The majority of the abuse of the children occurs at home.
   - Frequently it was the mother that was the abuser, with the father absent or passive. Today we are seeing more of the fatal and sexual abuse of children perpetuated by males.

2. Characteristics of Neglectful Parents.

   - Apathetic, ignore children.
   - May have been inadequately parented or neglected.
   - Have poor relationship with baby's father.
   - May have had difficult and complicated pregnancy.
   - Inability to organize a safe, warm home environment for their children.

3. Adults Who Were Sexually Abused as Children.

   - Tend to be fearful, anxious, depressed, angry, hostile and aggressive, suffer from low self-esteem, feel stigmatized, isolated.
   - May be sexually maladjusted.

EFFECT OF ABUSE/NEGLECT ON CHILDREN'S BEHAVIOR AND DEVELOPMENT

1. Characteristics of Abused Children.
    - May trigger abusive behavior of parents through no fault of his own.
    - May have been an unwanted pregnancy and birth, wrong sex.
    - May remind mother of hated father.
    - May have been low birth weight infant with physical problems or disabilities.
    - May have a temperament that is not congruent with that of the mother or of her expectations.

2. Early Signs of Abuse/Neglect.
    - Absence of synchrony (Infant and parent may seldom make eye contact with each other).
    - Failure to thrive, gain weight or grow normally and achieve developmental milestone in a timely manner.

3. Impact of Physical Abuse on Development on Children.
    - Delays in speech.
    - Preschoolers may be less independent, more resistant to, yet dependent on their mothers.
    - Tendency to be less persistent in tasks such as solving puzzles.
    - More negativistic, less enthusiastic.
    - Exhibit more hyperactive behavior and are more likely to be easily distracted.
    - Tend to be more hostile and anxious.
    - Exhibit more aggressive verbal and physical behavior towards their peers and adults.
    - As teenagers, they may exhibit wide variety of physical, cognitive and emotional disorders.

4. Effects of Neglect on Children.
    - Neglected children tend to display less self-confidence and self-assertiveness.
    - May lack persistence and the ability to stick to tasks.
    - May exhibit apathy and frequently withdraw from situations.
    - May be non-compliant and easily distracted.
    - Tend to be less aggressive than children who have been physically abused.
    - More likely to be victims of violence.

5. Symptoms of Sexual Abuse in Children.
    - Extreme changes in behavior.
    - Loss of appetite.
    - Sleep disturbances, fear of sleeping alone, nightmares.
    - Regression to earlier forms of behavior, such as bed wetting, thumb sucking.
    - Vaginal or rectal bleeding or discharge.
    - Vaginal or throat infections.
    - High irritability.
    - Painful, itching or swollen genitals.
    - Early precocity or interest in sexual matters.

- Intense fear or dislike of being left with a particular person.
- Increase in temper tantrums and other acting out behavior.
- Learning disabilities such as inability to concentrate, failing grades, lack of interest in school and school activities.

PRIDE IN PARENTING
ABUSE AND NEGLECT GUIDELINES

For Intervention Families:

When there is some concern about a family and there are thoughts about a possible protective service referral:

- PSS should share concerns with IDS who should alert FRS and establish if there are shared concerns.**
- The same would be true if the FRS had the initial concerns.
- Concerns should also be share with site supervisors.
- IDS might make a joint visit to the family with the PSS.
- A written summary of major concerns should be sent to project coordinator with plans to help mother better the situation. This should also be placed in the permanent file.

If concerns persist or feeling is action of an immediate nature is needed:

- Team should meet, including PSS, IDS, FRS and site supervisor, and reach a consensus* as to the action to be taken.
- BEFORE ANY ACTION IS TAKEN, the IDS involved should notify project coordinator. The project coordinator will contact the principal investigator. The project coordinator will then direct the staff as to what should be done, how and by whom. Another paragraph stating lack of change and continued concerns should go to the project coordinator; this should also be placed in the permanent file.

For Control Families:

- Since the FRS is the only staff involved, if there are concerns about a family they should be brought directly to the project coordinator.** The project coordinator will contact the principal investigator and then direct the FRS as to how to proceed.
- Written documentation should go in the permanent file as well as to the project coordinator.

* If no consensus can be reached, the project coordinator should be contacted.

** If there is a perceived threat of life, contact CPS immediately. Notify the project coordinator subsequently.

Unit 21
BEHAVIOR AND DISCIPLINE

Issues surrounding behavior and associated discipline are significant foci in parenting. As changes in behavior occur in growing children, many parents are unsure of how to respond. Many respond in punitive ways which are the only models they have ever had.

For the PSS to assist parents in disciplining they must have a good knowledge base about behavior and discipline. From this framework, they can educate and encourage parents in the PIP program. Ultimately, they can facilitate changes toward more constructive discipline and interaction.

Objectives

By the end of this unit, participants will be able to:

- List the common issues of behavior and discipline for parents of toddlers and preschoolers.
- Describe how development during these stages affects the issues of behavior and discipline and parenting approaches.
- Demonstrate how to talk to mothers about ways to discipline their children in non-violent, non-abusive, positive ways.
- Demonstrate an understanding of the continuity of development for issues of behavior and discipline in the stages before toddlerhood.
- Demonstrate developmentally appropriate ways to support parents in dealing with their child's behavior during toddlerhood and the preschool years.

Time

6 hours

Outline

A. Behavior and Discipline
B. Providing Guidance and Support
C. Summary and Review

Materials

- Shelov, S.P. & Hanneman, R.E. (1991). American Academy of Pediatrics Caring for Your Baby and Child: Birth to Age Five (pp.276-181, 313-316, 365-367). N.Y.: Bantam Books.
- Role Play Feedback **(Overhead #1)**
- Handouts from Parks, S. (Ed) (1988). HELP . . . At Home. Palo Alto, CA: VORT Corporation:
  - Beginning to Obey Simple Rules, p.449
  - Helping Me Learn Limits and Rules, p.406
  - Understanding Tantrums, p.408
  - Preventing Tantrums, p.409
  - What to do When a Tantrum Occurs, p.410
  - Tantrums at Their Peak, p.438

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Dictating and Demanding, p.451
Rituals and Routines, p.412
Transitions - Having a Tough Time!, p.452
Feeling Sad, Mad, Sorry, Worried, Scared, and More!, p.422
Coping with Fears, p.447
Feeling Frustrated, p.424
The "No" Stage continues!, p.435
Hitting, Biting and Pinching, p.436

- Role Play Scenarios **(Handout #1)**
- Blackboard and chalk or newsprint, makers and tape.
- Video: *"Shaking, Hitting and Spanking: What to do Instead"*, 1990 Gold Bill Products, Salt Lake City, Utah
- Post-Unit Test
- Post-Unit Evaluation
- TV, VCR, tripod, video camera and video tapes

Advance Preparation

- Review *Caring for Your Baby and Young Child*, information on Discipline: pp. 276-281 (1 - 2 Year Old), pp. 313- 315 (2 - 3 Year Old), and pp. 365-367 (3 - 5 Year Old).
- Review all handouts and use them to supplement information from other sources for mini-lectures.
- Make packets of handouts to be given to each participant
- Cut Role Play Scenarios into individual scenarios
- Bring a copy of S.P. Shelov and R.E. Hannemann's *American Academy of Pediatrics Caring for Your Baby and Young Child: Birth to Age 5.*
- Bring books, curriculum guides, and materials for parents which are available to Parenting Support Specialists to use with mothers and families.
- Review video, *"Shaking, Hitting and Spanking: What to do Instead"*.
- Set up and check video equipment. Set up video camera to record session and role plays.

A. BEHAVIOR AND DISCIPLINE (3 hours)

Rationale: If Parenting Support Specialists understand the usual course of development, not only can they help guide parents' expectations of the child, but they can also help parents learn effective, non-physical and non-emotionally abusive discipline practices.

Procedure: 1. **Participant discussion.** Begin by asking the trainees: What do you think are the biggest discipline problems for parents of toddlers and preschoolers? Process this discussion by writing the answers on a flip chart.

Tell the trainees that you want all of those who believe that spanking is to most effective method to change toddler's behavior to stand in one corner of the room. Ask those trainees who believe that spanking is not the most effective way to stand in the opposite corner of the room. Note, the size of each group. Ask the members of the two groups to share why they believe as they do.

Ask the trainees: What are the methods of discipline you have observed parents using with children of toddler and preschool age? Write answers on a flip chart.

Ask the trainees: Which of these methods do you think work best? Why? (Circle these methods on the flip chart.)

Which of these methods do you think are not good to use with infants and toddlers? Why? (Place an "X" in front of these methods on the flip chart.)

2. **Mini-lecture.** Discuss typical behavior and discipline issues for parents of the toddler and, in less detail, the preschooler using information in **Caring for Your Baby and Young Child**, pp. 276-281 (1 - 2 Year Old), pp. 313- 315 (2 - 3 Year Old), and pp. 365-367 (3 - 5 Year Old) and information from handouts listed under "materials" section. Encourage trainees to contribute to the discussion by giving examples of behavior and responses to the behavior by parents and other adults. Be certain to include in your discussion reference to developmentally appropriate ways of responding to the infant's behavior during the first year, **Caring for Your Baby and Young Child**, pp. 244-46.

3. Briefly discuss the difference between discipline and punishment. Review definition. Discuss discipline as a much broader concept than punishment. Point out that if punishment is used, the second form, the withholding of positive stimuli is preferred. However, the application of noxious stimuli is typically the one that is used by parents in most instances.

   a. ***Discipline:*** Training that is expected to produce a specified character or behavior, especially that which is expected to produce moral or mental improvement; Controlled behavior resulting from such training; A systematic method to obtain obedience; A state of order based on submission to rules and authority; Punishment intended to correct or train; A branch of knowledge or teaching; To train by instruction and control, teach to obey rules or accept authority; To punish or penalize; Syn. teach punish discipline. (American Heritage Dictionary).

Discipline is used to ultimately teach the child inner controls or self-discipline. This includes teaching how to achieve things, appropriate rules and behavioral guides, and how to develop a sense of pride when doing what is right.

b. Punishment is something that is used to get rid of a behavior and comes after the undesirable behavior has occurred. Some punishment is really violence against children. Punishment can take two forms:

  1. Apply noxious stimuli, aversive stimulation. Do something unpleasant, i.e. spanking, yelling, slapping, hitting, nagging, whining, pinching and shaking. Point out that no one should ever shake a baby or young child. It can lead to a subdural hematoma which can cause brain damage, blindness or can be fatal.

  2. Withholding of positive stimuli which are normally available, i.e. social interaction with friends and loved ones, play with favorite toy, "time-out" or no television. Shunning - Pennsylvania Dutch.

The research shows that process of the exclusive use of physical punishment is not the most effective way of disciplining children. It does not teach children what behaviors are appropriate and has many negative side effects.

4. Watch video, *"Shaking, Hitting and Spanking: What to do instead"*. Stop after each scenario. Discuss other options to behavior depicted, then watch scenario using more positive approaches to discipline.

   a. **Negative Side Effects of Punishment.** Show transparency of following information and have PSS discuss each point.

      1. May suppress the behavior rather than extinguish or eliminate it. (May learn to engage in the behavior more effectively, actually teaching them to be sneaky.)

      2. In the absence of the punishing stimulus, spontaneous recovery or reappearance of the behavior may occur. Child who behaves when father is around, Holy terror when he is not, mother forgot controlling strap (while the cat's away...)

3. Frequent hitting will cause a child to habituate or become used to the hitting. After a while, children who are spanked a lot don't mind being spanked.

4. Punishment may become reinforcing, a way of getting attention. Research shows that children may prefer negative attention to no attention at all.

5. Punishment may cause anxiety and instead of getting rid of may "fix" and increase the incidence of the undesirable behavior. For example, if a child is hit repeatedly for wetting the bed, this may make him so tense and anxious that the bedwetting increases instead of decreases.

6. Punishment may produce other emotional side effects anger, rage, fear, hostility, even hatred – especially if there is the perception that the punishment is unjustified.

7. Feelings about the punishment agent (belt, parent) may generalize and spread to the entire environment and result in avoidance behavior of running away.

8. Teaching child that aggressive behavior is the way to solve problems. A research study showed that children as young as 13 to 35 months of age were more aggressive towards their peers and caregivers in preschool than were a matched set of children that were not consistently spanked.

   The research shows that observational learning, modeling are powerful tools. Children tend to do more what they see you do, rather than what they hear you say.

9. Applying noxious stimuli does not provide suitable alternatives. Tells him what not to do, but does not tell him what is desirable. That is why second form is better. Have him think about what he did that got him into that situation.

b. Guidelines for Using Punishment (Infrequently).

1. Punishment should be done as soon as possible after the undesirable act, but not when the parent is extremely angry or upset. A time out is better in this situation.

2. Be consistent, otherwise you have put him on a variable ratio schedule of reinforcement and this will make the behavior very resistant to extinction. Gambling behavior.

3. Stay calm, however, show your displeasure appropriately through facial expression and/or tone of voice.

4. Do not withhold love as a punishment. Love should be unconditional and not contingent on desirable behavior. However, do not hug children immediately after punishing them. This sends mixed messages and can be extremely confusing. After a timeout, don't talk about problem, just go on with day as usual.

5. Be sure your expectations are developmentally appropriate.

6. Condemn the behavior, not the child. Never call him bad or dumb or stupid (that was a dumb thing to do; that was a stupid thing to do; how could a girl as smart as you do something so stupid).

7. Use punishment that is only strong enough to get the desired behavior.

8. Make consequences of an action relate to the misbehavior, i.e., if Kristie rides her bike outside the boundaries set, tell her she can ride where told or not ride at all, do not tell he she has to go to bed early, this is not related to the misbehavior.

9. Apologize if you make a mistake in punishment.

10. Use withholding of privileges rather than the application of noxious stimuli whenever possible. This way the parent can teach alternative desirable behavior. Have children think about it as they sit there and if they do not like that, then do not engage in the behavior that got them there in the first place.

c. **Positive Reinforcement** is the most desirable and most effective way of changing behavior. Use of praise and rewards to shape behavior is much more effective than punishment. The goal of discipline is to develop self control in the child. Discipline strategies:

1. Positive reinforcement. Find the good and praise it.

2. Use gentle guidance to teach new behaviors.

3. Sometimes use humor as a discipline tool.

4. Distract when appropriate. Ignore when appropriate

5. Discipline should work toward the preservation of self-esteem. Never humiliate a child in front of his peers by punishing him in public. If you must punish, do it discreetly.

6. Set a positive example.
7. Set clear limits but do not make them too narrow. Allow your child some freedom to explore within stated boundaries.

B. PROVIDING GUIDANCE AND SUPPORT (3 hours)

Rationale: In this part of the training, participants will examine ways to interact with infants and with parents around child development issues. It is important for Parenting Support Specialists to learn how to support and encourage without undermining the self-esteem of the parents.

Procedure: 1. **Review of Developmental Milestones.** Briefly review the milestones from one to two years by writing each developmental area (Movement, Hands and Finger Skills, Language, Cognitive, Social/Emotional) on a flip chart and asking the participants what they remember the baby is doing in this area during the period. Complete each area.

2. **Role Play Scenarios.** Ask each participant to select a partner or assign partners. One will play the Parenting Support Specialist and the other the mother. Then they will change. Have each pair draw a paper with a Role Play Scenario written on it. Remind the trainees that like the child you get in real life, the Scenario you get is "luck of the draw". It may or may not match with your own temperament or with the type of child behavior with which you are comfortable.

Give each of the participants a packet of the handouts on behavior and emotions listed under "materials" section.

Review the information on each handout within the developmental framework.

Give each team 20 minutes to decide how they will respond to the scenario using the handouts and other available materials.

Bring everyone back together and ask each team to play out its scenario with the mother introducing the scenario to the PSS. The PSS should talk to the mother as she would on a home visit. Following each scenario, process the activity by asking the participants doing the role play, then the rest of the participants the questions on Role Play Feedback **(Overhead #1)**.

After all pairs have had an opportunity to role play the scenarios, take a break, then repeat the entire role play scenarios activity with the partners switching roles.

C. SUMMARY AND REVIEW (15 minutes)

Procedure: 1. Rephrase the objectives on the first page of this unit as questions. Ask a volunteer to answer each question.

2. Ask participants whether the learning objectives they stated at the beginning of the unit were met. What information do they feel they still need behavior and discipline.

3. Distribute the post-unit evaluation forms.

4. Distribute post-unit test.

ROLE PLAY SCENARIOS

This should be done in pairs. One PSS plays the mother and the other plays the PSS. How do you think parents would respond? How could the PSS help in the situation?

1. Jalen who is 11 months old keeps putting his finger up to an electrical outlet although his mom has told him "no" repeatedly.

2. 12 month Daryl dropped a new vase on the floor and broke it. He started to cry.

3. 2 year old Donice hits her 8 month old brother with her toy car as he come near her.

4. 21 month old Shaquilla colored all over the living room walls with his new crayons.

5. Nikki's mom leaves a carton of eggs on the kitchen table while she goes to get the phone. 2 year old Nikki proceeds to drop the eggs on the floor.

6. Jamia's mom has started school. She drops Jamia off at a brand new sitter and Jamia starts to cry immediately.

7. 14 month old Takia wants her 3 year old sister's doll. She keeps trying to grab it.

8. 2 year old Lamont ran out of the fenced area in the back yard.

9. Mom was watching TV while she thought 33 month old Anissa was playing with her toys in her room. Her mom finished watching TV and came to find Anissa. She had poured juice over herself and the kitchen floor.

10. While shopping, 20 month old Alexis has a temper tantrum, screaming and kicking on the floor.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

POST-UNIT TEST

Name ______________________________

1. List five negative side effects of harsh physical punishment.

   A.

   B.

   C.

   D.

   E.

2. List two categories of punishment.

   A.

   B.

3. List three guidelines for using punishment.

   A.

   B.

   C.

Name the most desirable and effective way of changing young children's behavior.

POST-UNIT EVALUATION

UNIT COVERED: ______

DATE__________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? ______ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

Unit 22
HEALTH PROMOTION FOR FAMILIES

This unit of instruction will help the Parent Support Specialist (PSS) understand how a person can protect and improve their health and the health of their family members. The PSS will learn about their role in helping to teach their clients about the behaviors and actions that are related to their personal health and their families' health.

Objectives

By the end of this unit, participants will be able to:

- List the major characteristics of health within a definition of health.
- List many behaviors that promote health
- Describe and demonstrate ways to help families develop health promoting behaviors
- List 3 diseases or conditions that affect African-Americans and are preventable.

Time

5 Hours

Outline

A. Overview of Health Promotion
B. What is Health Promotion
C. Practical Exercises: Increasing PSS Health Promotion Skills
D. Helping Family Develop Healthy Habits
E. Summary

Materials

- Assorted brochures and pamphlets related to:
    Cigarette Smoking
    Blood Cholesterol
    Hypertension
    Weight Control
    Healthy Living
    Low Fat Eating and Cooking
    Alcohol
    Medications
    Exercises
- Health Habits Exercise–Personal Rating Form **(Handout #1)**
- Health Promotion Abstract **(Handout #2)**
- Role Play Feedback **(Overhead #1)**
- Post-Unit Test
- Post-Unit Evaluation
- Flip chart or chalkboard, markers or chalk
- Nutrition labels from popular/common food items
- Exercise video

Advance Preparation

- Gather an assortment of pamphlets and brochures from such groups as the American Heart Association, American Lung Association, American Diabetic Association related to smoking, eating, exercise etc.
- Prerecord on videotape exercise segments from ESPN programs or borrow Jane Fonda low impact videos, etc. from the library
- Encourage the PSS to wear or bring clothes for a very brief exercise session at the conclusion of this session.

A. OVERVIEW OF HEALTH PROMOTION

Rationale: It is important for PSSs to have a good understanding of what is meant by "health" in order to assist families towards a healthy life.

Procedure: 1. Ask the participants how they define health. Write ideas on chalkboard or flip chart.

2. Summarize the discussion. Be sure to include:
   - Health is a balance in the mind, body, spirit and environment characterized by:
   - stable emotions
   - a strong mind
   - a stable lifestyle
   - spiritual lifestyle
   - spiritual expression
   - a safe environment

3. Discuss the illnesses and diseases or conditions that affect African - American families that are preventable. Include the ideas that changing certain health habits and behaviors can prevent these illnesses and diseases and adopting healthy habits gives a feeling of well-being for all family members.

B. WHAT IS HEALTH PROMOTION

Rationale: The PSSs needs to be very familiar with health promotion and behaviors in order to assist families in making constructive changes.

Procedure: 1. Discuss health promotion as activities or behaviors that stop the development of a disease from becoming a serious illness or causing a handicap or death.

2. Define Health Promotion as involving:
   a. Improving the general health of a person or a family member. Some health promotion is done by the government such as:
      - clean water
      - garbage disposal
      - vitamins in milk and breads and cereals

   b. Some health promotion is done by a person or family members such as:
      - daily exercises
      - low fat eating
      - getting enough sleep at night

3. **National Health Promotion Goals for Healthy People 2000:** These health promotion goals are decided by the Federal government.
   - improve the health of infants
   - reduce the number of infants that die
   - improve the health of young adult women

THIS IS AN IMPORTANT GOAL OF THIS PROJECT AND WHAT YOU WILL BE DOING WHEN YOU VISIT FAMILIES IN THE HOME.

C. PRACTICAL EXERCISES: INCREASING PSS HEALTH PROMOTION SKILLS

Rationale: Practice is always important in integrating new information. Since this information will be integral to helping moms with health promoting behaviors, the PSSs need to "own" the information.

Procedure: 1. ***P.E. #1 (15 minutes)***

a. Hand out the Healthy Habits Exercise.
b. Ask PSS to rate their health habits using the Healthy Habits Exercise Rating Form.
c. Have the PSS add up their scores and rate themselves using the following scoring system.

27 - 30 points = EXCELLENT HEALTH HABITS

22 - 26 points = BETTER THAN AVERAGE HEALTH HABITS

18 - 21 points = AVERAGE HEALTH HABITS

< 15 points = POOR HEALTH HABITS

2. ***P.E. #2 (30 minutes)***
   a. Review Healthy Habits Score Sheet.
   b. Give each PSS an index card.
   c. Have each PSS write 1 health habit they wish to change.
   d. Pair the PSS.
   e. Each PSS exchange her card with her partner.
   f. Take 10 minutes and jot on the card what information she would ask her partner and then what suggestions she would make to her partner.

3. ***P.E. #3 (30 minutes)***
   a. Show flash card of various foods and have PSS identify which foods are high fiber, high fat, low fat, high or low calorie high or low salt, etc. (Try to use foods common to African - American family diet).

   b. Review nutrition labels. Ask PSS to identify fat percentage; calories/serving. Ask PSS which foods they would recommend.

4. ***P.E. #4 (30 minutes)***
   a. Have PSS talk about their own exercise habits. What have they done in the past? What do they do now? What would they like to do?

   b. Show some of the segments from pre-recorded T.V. shows (use low impact) Ask them to try a few of the exercises.

   c. End the session with some stretching exercises.

D. GOOD HEALTH HABITS: HEALTH PROMOTION BEHAVIORS

Review each of the following behaviors and discuss the obstacles in achieving these behaviors.

1. Sleeping 7 to 8 hours regularly
2. Eating breakfast regularly
3. Snacking on low fat and high fiber food
4. Maintaining near optimal weight
5. Exercising frequently (walking)
6. Consuming small amounts of alcohol
7. Avoid smoking
8. Avoid drugs
9. Safe sex
10. Eating less red meat (beef, pork, bacon)
11. Eating more chicken and turkey
12. Eating more fish
13. Eating more fruits
14. Eating more vegetables (raw, not cooked in fat or with meat)
15. Regular M.D. checks, Pap Smears, and Breast exams

E. HELPING FAMILIES DEVELOP HEALTHY HABITS

Rationale: Gathering information and using that information to facilitate changes will be critical to the PSSs intervention. Practice with gathering information, assisting mom in acknowledging areas needing change and empowering mom to make that change will assist PSSs with gaining important skills

Procedure: 1. PSS should gather information about family's health habits.

ASK QUESTIONS OR GET INFORMATION ABOUT:

a. How much sleep is the mother getting each day?

b. How much sleep is the infant getting?
SUGGESTION:
- Mom should sleep or nap when baby sleeps
- Can others help with night feeding so mom can sleep through the night
- Mom can change infant's sleep habits so both mom and baby can sleep at night.
- Relaxing strategies to help sleep, such as infant bath, rocking and singing softly before sleeping
- Infant feeding before sleeping (do not prop bottles)
- Try for quiet place
- Mom take a bath or shower before sleep
- Mom have a warm drink (milk, cocoa) before sleep

c. Mother's eating habits?

SUGGESTION:

- Have Mom recall what she ate for the last day
- PSS review for high fat, high salt, high calorie foods
- Suggest more vegetables and fruits (at least 5 selections a day)
- Low fat cooking such as baking, boiling
- How to reduce red meats
- How to add non meat protein (beans, low fat cheeses)
- How to read food labels

d. Does mother exercise? Does she have time to exercise?

SUGGESTION:

- TV exercise Programs (many are only 30 minutes)
- Stair Climbing (if there are stairs in the house; and when she has recovered, start with 3-4 times twice daily and increase)
- Walks, use the stroller and take baby (this is good for mother and baby; make sure safe area for walks, proper weather, proper clothes, etc.)
- Video exercise tapes that can be rented as well as bought.

e. Cigarette smoking? Mother? Other family members?

SUGGESTION:

- Point dangers of asthma and allergies for other infant and other children (Major killer of children among African - American families)
- Referrals or telephone numbers for Smoking cessation programs
- Smokers in family should smoke outside the home

f. Alcohol use or other drugs? Mother? Other family members?

- Is the mother concerned about her consumption or use of alcohol or drugs or the use by other family members

SUGGESTION:

- Referrals to organizations such as Alcoholics Anonymous, Narcotics Anonymous

g. Mom's Health

- Does mom have a doctor or clinic she visits regularly for her own health?
- When was mom's last GYN exam with Pap smear?
- Does mom know how to do breast self-examination?
- If mom is 35 or 40 years old, has she had a mammogram?

SUGGESTION:

- Referral for doctor or clinic
- Help mom make an appointment for next regular GYN exam and Pap smear (probably 1 year from last exam).
- Teach mom or review techniques for breast self-exam. Leave brochures behind related to breast self-exam.

- If PSS has a mom who is 35 or 40 years old, SHOULD REFER FOR MAMMOGRAM.

2. Help family to identify a habit(s) they may wish to work on first.
   SUGGESTION:
   - Have family only work on 1 or 2 lifestyle changes at a time
   - Check every 2 - 3 weeks, to see how Mom thinks the family is progressing
   - As mom is ready move to other health habits that she or the family wants to change, establish what she needs to achieve that goal. Assist as appropriate.

3. Using the above aspects of lifestyle and health status, as well as suggestions offered, pair PSSs, (one plays the mom and one plays the PSS). The PSSs should then role play how they would try to elicit information from mom, help mom identify changes needed and begin steps to make those changes. Give each pair 1-2 questions to focus on.

4. Leave appropriate materials (brochures) for the family.
   Review the printed materials with mother.
   Answers mom's questions.

F. SUMMARY

1. Rephrase objectives into questions and ask participants to answer questions
2. Distribute post-unit test.
3. Distribute post-unit evaluation.

HEALTH HABITS EXERCISE
PERSONAL RATING FORM

Use the following Personal Rating Form to score yourself on your personal health habits.

HEALTH HABIT	0 = NO/NEVER	1 = SOMETIMES	2 = OFTEN
1. Sleep 7-8 hours each night			
2. Eat breakfast regularly			
3. Eat low fat foods			
4. Near optimal weight			
5. Exercise frequently			
6. Alcohol - small amounts			
7. Avoid/no smoking			
8. Avoid drugs			
9. Safe sex			
10. Eat less red meat			
11. Eat more chicken and turkey			
12. Eat more fish			
13. Eat more fruits			
14. Eat more vegetables			
15. Regular doctor visits			

HEALTH PROMOTION ABSTRACT

Health Promotion Behavior in Low Income Black and Latino Women by Kathy Sanders-Phillips, PhD, Women & Health, Vol 21, (2/3), 1994.

Health promotion behaviors were examined in a sample of low-income, Black and Latino women. Latino women were more likely than Black women to eat a daily breakfast; sleep 7-8 hours per night and abstain from alcohol and tobacco use. Black women were more likely to be eating vegetables on a regular basis and exercising at least once per week. The results suggest that low-income Latino women may need to increase their consumption of vegetables and frequency of exercise. Among Black women, a wider range of healthy lifestyle behaviors such as sleeping 8 hours per night, eating a daily breakfast and decreasing alcohol and tobacco consumption may need to be emphasized.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

POST-UNIT TEST
HEALTH PROMOTION FOR FAMILIES

I. List a least 3 characteristics of health. (3 points):

____

____

____

II. Health Promotion Behaviors (5 points)

Indicate which of the below is a health promoting behavior (T – True) or is not a health promoting behavior (F – False).

______ 1. Sleeping 6 - 7 hours a day.

______ 2. Eating breakfast regularly.

______ 3. Keeping weight below the normal range.

______ 4. Moderate regular exercise.

______ 5. Eating balanced amounts of red meat, fish and chicken.

III. Health Promotion for Families (2 points)

List at least 4 ways the PSS can help families to develop health promoting behaviors.

____

____

____

____

POST-UNIT EVALUATION

UNIT COVERED: ______

DATE________________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

Unit 23
MAINTAINING PERSONAL SAFETY

Some of the families recruited for the Pride in Parenting program will reside in neighborhoods with high crime levels. In order to assure the personal safety of the PIP Parenting Support Specialists while working in the community, Project Administrators will work with legal enforcement agencies in the neighborhoods. This session is designed to enhance the ability of PSS's to function safely in their community activity.

Objectives

By the end of this session, participants will be able to:

- Describe pre-visit planning to improve safety of the visit.
- Describe rules for personal attire to improve safety on home visits.
- Describe procedures for maintaining car safety on visits.
- Describe cautionary practices on the street and in entering buildings.
- Demonstrate behavior to ensure personal safety in the event of family violence during a home visit.
- Demonstrate behavior to ensure personal safety if illegal activities are conducted in the home.
- Demonstrate behavior strategies to use if accosted.
- Describe procedures to report incidents that compromise PIP staff safety.

Time

6-8 hours

Outline

A. Safety Issues When Planning a Visit
B. Street Safety
C. Personal Attire for Safety on Home Visits
D. Car Safety
E. Safety During the Visit
F. Role Plays
G. Self Defense
H. Incident Reporting
I. Summary and Review

Materials

Articles about personal safety during home visiting such as:

- Nadwairski,J. (1992). Inner-city safety for home care providers. JONA, Vol. 22, (No.9).
- Wheeler, B.G. (1993). Crime in public places: Are you an easy mark? Women's Day, pp. 63-67, 123.
- Washington, H. (1994). Don't be scared - Be prepared. Heart & Soul.
- Articles from local Police Department.
- Safety in the Community: Preliminary Preparations for Visits and Personal Attire **(Handout #1)**
- Street and Home Safety **(Handout #2)**
- Car Safety **(Handout #3)**
- Personal Safety Scenarios **(Handout #4)**

- Incident Report Form **(Handout #5)**
- Safety: Always Observe Your Surroundings **(Handout #6)**
- Role Play Feedback **(Overhead #1)**
- Post-Unit Test
- Post-Unit Evaluation

Advance Preparation

- Review articles.
- Have sufficient copies of handouts.
- Arrange for speaker from local Police Department to address personal safety issues in detail with the group.
- Arrange for self-defense expert to come and teach some basic techniques.

A. SAFETY ISSUES WHEN PLANNING A VISIT

Rationale: Parenting Support Specialists will need to assess how to conduct home visits while assuring personal safety. Information gathered prior to the visit will enable them to foresee or avoid potential risks.

Procedure:
1. Review of general guidelines for information gathering for safety planning prior to visit. Look at maps and do drive through community with a partner.
2. Review areas of city in which a particular caution should be exerted. Escorts and/or cellular phones should be considered.
3. Suggested hours for conducting home visits – when to avoid visits. Remember to avoid days when public assistance checks come.
4. Review "Safety in the Community." **(Handout #1)**

B. STREET SAFETY

Rationale: Participants will review strategies for personal safety in moving about the community.

Procedure:
1. Discussion led by local police.
2. Review "Street and Home Safety." **(Handout #2)**

C. PERSONAL ATTIRE

Rationale: How you dress can have an important impact on moving around the community safely.

Procedure:
1. Discussion led by local police.
2. Review "Personal Attire". **(Handout #1)**

D. CAR SAFETY

Rationale: Using a car on home visits requires certain safety considerations.

Procedure:
1. Discussion led by local police.
2. Review handout "Car Safety". **(Handout #3)**

E. SAFETY DURING VISITS

Rationale: PSS's may be exposed to family violence and illegal behavior during the visits. Knowledge of guidelines to follow in these circumstances will improve personal safety.

Procedure:
1. Review of some of the family violence issues covered in Unit 21.
2. Discussion led by local police:
   - about strategies for dealing with domestic arguments.
   - of strategies for dealing with hostilities directed toward the PSS.
   - of procedures when drug activity is going on in the home.

F. ROLE PLAYS

Rationale: This is to prepare participants to handle difficult situations during home visits.

Procedure:
1. The group will form teams of 3. One member will play the role of PSS. The other two will be the mother and another family member.
2. Teams will review scenarios and act out the situations **(Handout #4)**. The PSS will follow recommended practices.
3. The group will discuss and critique the approaches selected by the team. Use Role Play Feedback **(Overhead #1)** to guide discussion.

G. SELF DEFENSE

Rationale: If the participant is physically threatened, specific defensive actions can be employed.

Procedure:
1. Discussion and demonstration by self-defense expert.
2. Participants will practice the techniques.

H. INCIDENT REPORTING

Rationale: Project administrators need to be aware of threats to safety of project staff to prevent future occurrences.

Procedure:
1. Discussion of type of incidents that will warrant reporting.
2. Discussion of procedure for notifying supervisor.
3. Review of incident report from. **(Handout #5)**
4. Distribute Safety: Always Observe Your Surroundings **(Handout #6)** for each PSS to post at their site.

I. SUMMARY AND REVIEW

1. Rephrase objectives into questions. Elicit answers from all participants.
2. Distribute post-unit test.
3. Distribute post-unit evaluation.

PRIDE IN PARENTING
SAFETY IN THE COMMUNITY

PRELIMINARY PREPARATIONS FOR VISITS

- Review family history for drug abuse, mental illness, violence.
- Check address on street map.
- Arrange visits in unknown areas or especially risky areas for early in the day (10:00am - 12:00 noon).
- Unless you are very comfortable in the area, plan to complete your visits by 3:00pm.
- Review travel route. Look for alternate route in case needed.
- Telephone family for suggestions about parking and entering building name and telephone of building captain, how to get to their apartment in the building.
- If uncertain, arrange for family to meet you outside building.
- If necessary arrange escort.
- If family suggests, arrange alternate location than the apartment to meet (restaurant, coffee shop).
- Notify coordinator about day's travel plan prior to departure – call parent before you depart.
- Call building captain to inform of your planned arrival time and future visiting schedule.
- IDS at each site will determine if weather conditions require cancellation of visits.

PERSONAL ATTIRE

- Wear casual clothes, preferably slacks and flat shoes – nothing tight, short or flashy.
- Don't wear jewelry, even costume jewelry.
- Don't carry a purse, use clear plastic carry all. Have change for a pay phone or carry a cellular phone.
- Keep keys in pocket for ready access. Keep a second set in your notebook or tote bag.
- Keep a couple of dollars in a money clip to throw if you are held up.
- Wear the PRIDE IN PARENTING staff identification.

STREET AND HOME SAFETY

- Walk with a confident attitude.
- Don't walk through a crowd. Stay near the curb when walking or the sidewalk.
- Be aware of the surroundings. Don't use a walkman.
- If you feel threatened, go into a store.
- If using buses, know the schedule and avoid long waits at the stop; don't wait at an isolated stop.
- Don't approach homes with threatening looking dogs. Ask the owner to hold the dog.
- Call ahead. Consider having the mother meet you in the lobby or at the front door.
- When entering a new building, stop to meet the building captain or other supervisory personnel and explain your visit plans.
- Use elevators, not stairs – if the elevator is broken, have the mother come down.
- Call the office and the next mother when departing for the next visit. Call the office after your last visit.
- Don't carry a weapon. Have pepper spray or a siren for protection.
- Greet neighbors, be introduced, get known.
- Don't respond to verbal taunts.
- Before you knock, listen at the door. If you hear a loud argument, leave. If an argument escalates during the visit, leave.
- Be aware of exits in the home and building.
- Avoid dark corners, unlit hallways, extreme quiet.
- Be extremely cautious and report to supervisor any homes where there is extreme activity, entrance that has a crowd of people, a mother's unwillingness to talk when partner is around, sudden changes in personality.
- Report any incidents of family violence, drug use, or if you are threatened, to the team coordinator.

USE YOUR INTUITION. IF YOU ARE UNCOMFORTABLE
DON'T GO IN OR LEAVE IMMEDIATELY.

CAR SAFETY

- Know exactly where you are going. Have travel route mapped out and an alternate route. Have a list of that day's visit addresses and phone numbers in the car. Leave a daily visit plan back at the office with your supervisor.
- Lock pocketbook in office or in car trunk before you leave your home site parking lot. Have the forms that you need for that day's visit in your tote.
- Check your gas.
- Lock your doors, leave windows open only a few inches if you must.
- Don't leave briefcases etc. visible in the car.
- Observe street activity as you arrive at your destination.
- Park near building. Avoid isolated streets and groups loitering on street.
- Have your keys ready in hand when returning to your car.
- Check the backseat before getting in.
- Keep emergency towing number handy in your car.
- Leave the "Pride in Parenting" sign on your dashboard.
- In winter, keep a shovel and kitty litter in your trunk.
- If your care breaks down and you are uncomfortable waiting for help, call a cab or take public transportation back to hospital or home.

PERSONAL SAFETY SCENARIOS

1. You are assigned a new mother to visit but you are not familiar with her building. You know that her street is one with a lot of drug activity. What do you do to prepare for this visit. What do you discuss with the mother when arranging the visit?

2. You are visiting a mother when her boyfriend, who is very drunk, comes in and starts yelling at the mother. What do you do?

3. You realize you probably have a flat tire as you are driving into your client's neighborhood. What do you do?

4. You arrive at the client's apartment and there is a group of men who go into the back bedroom. What do you do?

5. You are walking down the street and start to feel that two teenage boys are following you. What do you do?

6. You are talking with the mother when the father starts to physically discipline the 4-year-old. What do you do?

INCIDENT REPORT

Person reporting:

Date of incident: Time occurred:

Location of incident:

Name of participating family:

Persons present:

Describe incident:

Incident reported to:

Recommendations:

SAFETY
ALWAYS OBSERVE YOUR SURROUNDINGS

- People in and out of house with a lot of activity
- Long dark corridors
- Extreme quite
- Someone making loud noises after real quiet
- Do not pass dark corners
- Too many people standing around blocking entrance
- Light bulbs out in hallways/stairwells
- Continuous escalating argument
- Mother unwilling to talk if dad is around
- Sudden changes in personality

Precautions to take....

- Call before you go on visit
- Look at traffic pattern and be aware of exits available
- Put purse in trunk before you go to visit
- Wear little jewelry
- Dress appropriately to neighborhood and clientele.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

UNIT TEST
Child Growth and Development
One Month to Four Months

1. Describe 4 preliminary preparations to make before doing home visits.

2. Describe what personal attire is appropriate for home visiting.

3. Describe 5 behaviors that are important for street and home safety.

4. What car safety precautions should be taken when home visiting?

5. Describe a situation you could encounter on home visit that you would consider dangerous. Describe what would be appropriate behavior or actions.

POST-UNIT EVALUATION

UNIT COVERED: ______

DATE______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? ______ If not, please explain.

Unit 24
SUBSTANCE ABUSE

Women who fail to obtain adequate prenatal care often have factors in their lives that are so disruptive that they cannot organize their lives to include time for prenatal care. Too often one of these factors is substance abuse - either by the mother herself or a significant other in her life.

This unit is designed to help participants understand the impact of the use of drugs with addictive potential and alcohol on the mother, the infant and parenting.

Objectives

By the end of this unit participants will be able to:

- Describe 3 factors related to addiction severity.
- Assess their own attitude about drug use and abuse in pregnancy.
- Discuss 3 risks of substance abuse to both pregnant and post-partum women.
- Identify the common names of 3 illegal drugs used and describe their effects on the woman.
- Identify 5 potential effects of intrauterine drug exposure on the newborn.
- Identify at least 5 symptoms of drug withdrawal in the newborn.
- Describe 3 techniques parents can use to comfort babies who were exposed to drugs in utero.
- Identify 5 psychosocial/environmental factors of addiction.
- Demonstrate knowledge of the meaning of addiction.
- Describe 3 important factors in beginning intervention with mothers who are substance abusers.
- List 6 stressors of working with this population.
- Describe one long-term effect of each drug (cocaine, heroin, marijuana, alcohol, smoking and prescription drugs) on the growth and development of prenatally exposed children.
- Describe the types of resources that may be needed to optimize development in the children who are drug exposed.

Time

9 hours

Outline

A. Introduction/Attitudes about drug use/abuse in pregnancy
B. The substance abusing pregnant woman
C. Commonly used substances and their effects on mother and infant
D. Techniques parents can use to comfort the substance exposed infant
E. Working with mothers who are substance abusers
F. Long-term effects of prenatal drug exposure on child development & behavior
G. Intervention approaches
H. Summary and review

Materials

- Ryan, L., Ehrlich, S.J. & Finnegan, L. (1987). Cocaine Abuse in Pregnancy: Effects on the Fetus & Newborn. Pergamon Journals ltd, Vol. 9, pps. 295-299.
- Puttkammer, C. (ed.) (1994). Working with Substance-Exposed Children. Arizona:Therapy Skill Builders.
- McGoldrick, M. (1985). Genograms in Family Assessment 1st ed. N.Y.: Norton.
- Attitudes about drug abusing during pregnancy: Staff questionnaire. **(Handout #1)**
- Drug Effects on Mother **(Training Aid #1)**
- Obstetric Complications Associated with Addiction **(Training Aid #2)**
- Drug Information Guide **(Handout #2)**
- Drug Effects on Child **(Training Aid #3)**
- Identified fetal risks from cocaine **(Training Aid #4)**
- Neonatal Withdrawal Symptoms **(Training Aid #5)**
- Cigarette Smoking **(Training Aid #6)**
- Abnormalities Due to Prenatal Alcohol Exposure **(Training Aid #7)**
- How to Comfort Infant **(Handout #3)**
- Case Study **(Handout # 4)**
- Case Studies **(Handouts # 5a, b, c & d)**
- Video "Treatment Issues for Women" National Institute on Drug Abuse. NCADI Video Resource Program.
- Role Play Feedback **(Overhead #1)**
- Post Unit Test **(Handout #6)**
- Post Unit Evaluation **(Handout #7)**
- Baby Doll
- Blankets
- Video Equipment: video camera, tripod, tape, VCR, and TV

Advance Preparation

- Read above article - Cocaine Abuse in Pregnancy.
- Review Working with Substance-Exposed Children.
- Determine what support groups are available for substance abusing women with children in your local area.
- Review video.
- Meet with local support groups and solicit their participation.
- Prepare handouts and transparencies from training aids.
- Become knowledgeable about public assistance eligibility in your area; contact experts for assistance.
- Try out video equipment. Set up camera to videotape role plays.

A. INTRODUCTION/ATTITUDES ABOUT DRUG ABUSE IN PREGNANCY (1 ½ hours)

Rationale: It is important for the trainer to recognize that there may be significant judgmental perceptions held about persons who abuse drugs that can interfere with a PSS's ability to either recognize a situation in which drugs are being used or in assisting a client in managing the choices they have made. The PSS's attitude about drug users will be key in working successfully with these mothers. Being armed with compassion, knowledge and alternatives will be important so that the PSS will have credibility in the eyes of their clients.

Procedure: 1. Begin the session with the attitude survey (**Handout #1**).

2. Collect survey and keep them; participants will repeat the survey at the end of the training and compare.

3. Have an open discussion about the three most provocative issues on the survey. (Suggestions # 2, 4, 10, 30, 33, 35)

B. THE SUBSTANCE ABUSING PREGNANT WOMEN (1 hour)

Rationale: The fact that drug abuse in child-bearing women has been increasing just as explosively as in other populations in America may not be fully appreciated by the general population or even some groups of health care providers. Currently the incidence is estimated to be between 10 - 25%. Quite often the diagnosis is missed because mothers do not always have the so-called classic appearance of a drug user and may be hesitant about reporting their drug use. It is important for the PSS to be aware of both the obvious as well as the subtle indications of substance use by women with children

Procedure: Lecture format. Use the Training Aids **#1** and **#2**, discuss the details delineating characteristics in these areas about women who use substances. Elicit thoughts and questions from participants.

C. COMMONLY USED DRUGS AND THEIR EFFECTS ON MOTHER AND INFANT (2 hours)

Rationale: Since we will be working with mothers who are substance abusers and will be trying to facilitate good parenting skills and health care utilization, it is important to know as much as we can about factors related to the substance abuse. PSSs need to be familiar with commonly used drugs, their street names and the potential effects of the drugs on mother and infant.

Procedure: ***Procedure:*** **1.**Discuss the following factors assessed when evaluating addiction severity:

a. Biological/Consumption Indices:
   - For example, how often, for how long, how much, what drugs.

b. Economic Indices:
   - For example, for maintaining employment, criminal behavior - how much is spent.

c. Social Indices:
   - For example, unstable environment including relationships, housing, income, support systems.

d. Personal/Personality Indices:
   - This is related to addiction not to a specific drug.
   - For example, denial about our behavior, low self-esteem, depression, mood fluctuations, distrustful of others, unintentional pregnancy. At some level, the unintentional pregnancy could be related to emotional and financial needs.

2. Lecture format. Give out Drug Information Guide (**Handout #2**). You could enlist the aid of a police drug education officer to familiarize PSS with drug paraphernalia if appropriate.

3. Use Training Aids **#3** through **#7** and discuss the details of the effects of drugs on mother and infant.

4. Elicit questions from the group.

D. TECHNIQUES PARENTS CAN USE TO COMFORT THE SUBSTANCE EXPOSED CHILD (1 hour)

Rationale: Because all of the drugs used can impact the developing nervous system, these infants may have temperaments that can challenge the usual means for providing comfort for baby. Additionally, the parenting skills of these mothers may be lacking because they themselves have had no role models. Often their expectations for what an infant should do are very unrealistic. The PSS must recognize that she/he may be confronted with two persons who are withdrawing from drug exposure which can be an explosive situation especially when one of those persons (mother) is responsible for caring for the other person (baby) who is uniquely vulnerable. These techniques may help empower the mother to assist her infant about whose symptoms she may feel tremendously guilty.

Procedure: 1. Distribute **Handout #3**, review each technique in detail. May use doll to demonstrate various holds, wrapping or cuddling techniques.

2. Discuss other ways to be of support to a mother who is a substance abuser.

E. WORKING WITH MOTHERS WHO ARE SUBSTANCE ABUSERS (2 hours).

Rationale: Since the PSSs will be going into homes of mothers who are substance abusers, they need to have a good understanding of factors related to addiction, techniques for intervention and stressors that they may encounter.

***Procedures*:** **1.** Ask participants what they think is a good definition of addiction. Write this on a flip chart. Discuss the dictionary definition and compare it to their definition. Have trainees share any experiences they have had with people who abuse and are addicted to substances.

> Definition of addiction: From Webster's Dictionary "A compulsive need for and use of a habit-forming substance characterized by tolerance and by well-defined physiological symptoms upon withdrawal." Drug addiction is a disease. This is behavior driven, has a biochemical element, and there is continued use even though it is harmful. This is a medical problem requiring treatment.

2. Psychosocial/Environmental Factors of Addiction

a. Characteristics and behavioral expectations
- hyperactive state on cocaine; lethargic state on heroine.
- low self-esteem
- emotional/mental health issues
- poor hygiene
- poor eating habits
- poor communication/interactive skills
- poor parenting skills
- dysfunctional family units
- short term incarceration

Discuss each of the above factors and their potential influences on parenting and on involvement in the PIP program.

b. Environmental factors of addiction
- transiency
- economic issues
- surroundings - people and places

Discuss the above factors and how they might effect working with these mothers.

3. Cycle of Addiction

a. Generational
- history of intergenerational drug dependency

- history of physical, sexual and/or psychological abuse
- unstable caregiving environment
- history of criminal activity

Introduce the use of genograms to map family history. This can be used with mothers in the PIP program to facilitate their understanding of their addiction.

Use case study (**Handout #4**) to do a genogram as a group. Have everyone involved in diagraming the family. Make a special notation on each member in which there has been drug abuse. Discuss how families can impact their members. Refer to Training Unit 6, Working With Families.

b. Present day stressors
  - loss of employment
  - lack of basic necessities
  - personal loss
  - loss of social support
  - impact of welfare reform

Watch video "Treatment Issues for Women" and discuss salient issues and their potential impact on the PIP mothers and the PSSs working with them.

Since welfare criteria are changing, be able to discuss the present status of welfare in your area or bring in an expert who can speak in detail to the trainees.

4. How to begin intervention
  - Review paperwork already completed.
  - First contact should be in the hospital before discharge.
  - "Window of opportunity" - schedule first home visit within 48 hours of the homecoming. This is most likely when the mom will be clean.
  - Acknowledge drug use; extend support, respond to expressed concerns and then proceed to the project's priorities i.e. parenting, child development, health care utilization.

Practice the initial home visit with one PSS playing that role and one PSS playing the role of the new mother. Be sure everyone has a chance to play both roles. Use role play feedback form (**Overhead #1**) to guide discussion.

5. Stressors on PSSs - much frustration is experienced when working with this population. The situations that follow are some of the most common frustrations:
  - phone disconnected
  - having the wrong address/transiency
  - falsification of information by the mother
  - unreliability regarding scheduled visits and groups
  - denial that anything is wrong

- clients often disappear only to reappear when their needs are great.
- use of PIP as a protector against legal issues and government entitlement issues, i.e., drug treatment may be mandated by child protective services as the basis for keeping the children in the home. Mother gives our name as fulfilling this obligation although we do not do primary drug treatment.
- placement of infant with a variety of people.
- many agencies involved; unclear as to roles of each one.

Review each stressor. Have trainees discuss how they may be affected by these situations.

6. How to keep up PSSs motivation to work with these mothers who are substance abusers.

- Have clear program policies and procedures that set the boundaries of program.
- Team support both in 1 to 1 and group situations.
- Find satisfaction in small steps of progress.

Discuss how these techniques could help the PSSs. Elicit other strategies that they think will be useful.

7. Use case studies (**Handouts #5 a,b,c**) to have group identify important issues to focus on at different points in the intervention.

F. LONG TERM EFFECTS OF PRENATAL DRUG EXPOSURE ON DEVELOPMENT AND BEHAVIOR (1 ½ hours)

Rationale: Much has been presented in the popular media about effects of drug exposure. PSSs need to be aware of facts and fiction in outcomes for these children.

Procedure: **1.** Have group discuss what they have heard in the media about development of kids exposed to cocaine; to heroin; to alcohol.

2. Discuss with the group reasons why many research studies may be flawed, making findings questionable.

- Difficult to follow long term, most only to age 2 or 3 years.
- Multiple drug use common, difficult to tell effects of a single drug because combined.
- Mother's report of what she used, how often, and how much may not be reliable.
- Mother may not provide environment conducive to good development.
- Children often are outplaced and have multiple foster situations; over 30% receive placements.
- Increased rate of prematurity and developmental risks associated with prematurity.

3. The group leader will present current research findings on the effects of prenatal exposure to the following substances on child growth and development. In drug abuse situations, poor environment seems to play a large role in long term outcomes.

a. Effects of cocaine: (high overlap of use in conjunction with marijuana and tobacco)

1) Growth

- Many have lower birth weight (but also more prematurity) and smaller head size (a measure of brain growth) at birth.
- Growth improves showing catch up to normal peers but head size often remains smaller.

2) Cognitive abilities (intelligence)

- Most studies do not find differences in overall IQ when tested at 2 and 3 years.
- A few studies find more language delay after 2 years.
- Low SES population, in which there is higher rates of cocaine use, generally have low average IQ and language is greatest area of weakness.

3) Behavior

- Shift from being overactive in newborn period to being more lethargic and difficult to engage after 3 months. May still show some hyperactivity and transient hypertonia, tremulousness at 4 months. Possible risk then for mother to feel less successful in interaction with infant.
- Another study of full-term cocaine exposed infants found no behavioral differences after birth.
- Preschool play behavior indistinguishable from unexposed peers.
- Greater tendency for children from low SES, dysfunctional families to show greater hyperactivity, poor attention and aggression.

4) Health implications

- Greater incidence of prematurity increases incidence of disabilities associated with prematurity: Respiratory difficulties, learning disability, attention problems, cerebral palsy, mental retardation.
- Increased incidence of strokes in utero. May have hemiplegia.
- Increased incidence of malformations, especially of genito-urinary tract.

b. Effects of heroin (usually seen as poly drug use: opiates, methadone)

1) Growth

- Smaller at birth but normal weight and length by 12 months - improved feedings after first few weeks.

- May be persistent small head circumference as in cocaine.

2) Cognitive development

- No difference in IQ scores or motor development - scores in normal range at 6 months and after.

- Some reports of delay in fine motor and language skills - but some studies find no differences.

3) Behavior

- Newborn behaviors of irritability, overreaction to sound.

- For some persistence of irritability up to 6 months, but there is improved interaction and responsiveness.

- Later behavior marked by poor attention and impulsivity; contribute to management problems; one study says 40% need special education due to behaviors.

4) Health Implication

- Children of IV drug abusers and partners of IV drug users at risk for AIDS. Mother who is HIV+ can transmit to infant about 1/3 of the time.

- Baltimore study of pregnant poly drug users found 40% were HIV positive.

- If HIV positive mother takes AZT during pregnancy she reduces transmission rate to infant by 2/3.

- HIV positive infants show two pictures:

  a) Rapidly become symptomatic and die by age 2.

  b) Long period of asymptomatic become symptomatic in preteen but may live into teens.

  c) Some revert to normal - serum conversion when baby develops own antibodies and not displaying moms (up to 2 years).

- Symptomatic infants show failure to thrive, pneumonia, eczema, motor deterioration; chronic illness.

- Many participate in medication trials.

- High rate of STD's among poly drug users which may be transmitted to infant; as result of STD can have damage to the central nervous system or vision.
- Infants exposed prenatally to methadone may have higher risk for SIDS.

c. Effects of alcohol abuse

1) Growth
- Small for gestational age.

- Usually continue to show poor growth with frequent diagnosis of failure to thrive.

2) Cognitive functioning
- Children with full syndrome (FAS) generally show borderline to mild retardation but can show full range to severe retardation as well.

- Children with Fetal Alcohol Effects (FAE) usually borderline to low average intelligence and learning disabilities.

- FAS children often show motor delays and may have joint contractures that impair mobility.

- Fine motor and perceptual skills often delayed.

- Show poor auditory memory.

3) Behavior
- Usually are sociable but show very poor attention and impulsivity. This is seen even in those children reared in foster care.

- As grow show poor judgment and inability to foresee consequences of actions.

4) Health implications
- Poor suck and vomiting can persist the first 6-7 months so they are frustrating to feed.

- Continue to show poor appetite and weight gain.

d. Effects of Marijuana

1) Growth
- Low birth weight and decreased fat stores.

- Suggests hypoxic e[illegible] also seen from cigarette smoking.

2) Cognitive development
- Very few studies: One showed no differences in developmental scores of 12 or 24 month, but at 4 years exposed children had poorer memory and verbal scores on an IQ test.

- Another study at 4 years did not show this.

e. Effects of Tobacco Smoking

1) Growth
- Significantly smaller at birth.

2) Cognitive development
- Some suggestions of poor attention and learning disabilities.

3) Health
- Increased respiratory illness if exposed prenatally but especially from passive exposure postnatally.

- Increased risk of SIDS.

f. Effects of prescription drugs

1) Lithium, used for treatment of manic-depressive illness, leads to severe cardiac abnormalities and should be avoided in pregnancy.

2) Sedatives
- Valium, Clonipin, Xanax - some reports of increased incidence of cleft palate.

- Thorazine - Can cause urinary retention and dystonia in infant; may be a mild withdrawal syndrome.

H. INTERVENTION APPROACHES (1 hour)

Rationale: When working with children who are drug exposed, PSSs need to be familiar with the types of resources that may be required to optimize the children's development.

Procedure: **1.** The group leader will lead a discussion of recommended intervention for children exposed to ATOD.

a. Home management
- Parent needs to be aware of early behavior patterns for consoling, engaging and for feeding.
- Provide recommendations helpful for managing attention deficits and hyperactivity.
- Need clear expectations, regular routines, help with transitions.
- Avoid overstimulation and fatigue.
- Use of positive reinforcement and time-out for managing aggression.

b. Educational programs
- If a parent is very dysfunctional, daycare program for infant may be helpful.
- At preschool level direct to Headstart.
- Attention deficits may make eligible for special education - smaller classes, more structured program.
- As ready for school entry, full developmental assessment may be needed to determine special educational needs.

2. Session leader will open discussion of other anticipated resources needed and agencies that may approach "one-stop shopping" recommended for mothers who abuse substances.

I. SUMMARY AND REVIEW (30 minutes)

1. Rephrase the objectives on the first page of this unit, with the exception of the first objective, as a question. Ask for volunteers to answer each question.
2. Repeat Attitude Survey test/Review and discuss changes since first attitude survey.
3. Distribute post-unit test.
4. Distribute post-unit evaluation.

Attitudes about Drug Abuse in Pregnancy: Staff Questionnaire

I. Demographic Information: We would like your opinions about the consequences of substance abuse in pregnancy. Please begin by filling out the demographic information in the first section. All information that you give us will be anonymous and confidential.

Where Employed: ____________________ Unit: ____________________
Staff Position: ____________________ Shift: ____________________
Education: ____________________
Number of Years Employed in your Profession: __________
Length of Time in Current Position: ______________
Age: ____________ Sex: M F Ethnic Group: ____________________
Have you had any training or inservices on drug abuse or the effects of prenatal exposure:
____

II. Questionnaire: Below are 50 statements about the effects of prenatal substance exposure, addiction, and its effects. Please indicate how much you agree or disagree with each statement by circling the number which corresponds to your choice.

	Strongly Agree	Agree	Not	Disagree	Strongly
1. Most infants with prenatal cocaine exposure have no long-term deficits.	1	2	3	4	5
2. The best thing to do for a drug-exposed baby is to place it in foster care.	1	2	3	4	5
3. There are clear differences in the effects of prenatal exposure to alcohol and cocaine.	1	2	3	4	5
4. In general, illegal drugs seem to have more serious consequences for prenatally exposed babies than legal drugs.	1	2	3	4	5
5. The government is not doing enough to stop the influx of illegal drugs.	1	2	3	4	5
6. As a result of the increase in cocaine use, there are many more preterm babies with serious medical problems.	1	2	3	4	5
7. Substance abusers usually stick to a single drug rather than using a variety of drugs.	1	2	3	4	5

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	Strongly Agree	Agree	Not	Disagree	Strongly
8. The withdrawal from cocaine experienced by infants can last several months.	1	2	3	4	5
9. Women often use cocaine to induce abortions.	1	2	3	4	5
10. Black women are more likely to use drugs than Whites or Hispanics.	1	2	3	4	5
11. It is difficult for pregnant women to get treatment for substance abuse.	1	2	3	4	5
12. Health care professionals who deal with mothers and babies should be taught how to identify signs of substance abuse.	1	2	3	4	5
13. Prenatal addiction causes changes in the brain that make a child more likely to become an addict or alcoholic later.	1	2	3	4	5
14. Pregnant women who use drugs should be put in jail.	1	2	3	4	5
15. Cocaine is often used by women who don't abuse other drugs.	1	2	3	4	5
16. Alcohol and drug use are caused by genetic traits.	1	2	3	4	5
17. All pregnant women should be given a urine screen for drugs.	1	2	3	4	5
18. Cocaine is more damaging to the newborn than other drugs.	1	2	3	4	5
19. Women who use drugs and alcohol usually associate with men who do too.	1	2	3	4	5
20. Among alcoholic women, the risk for having a child with fetal alcohol syndrome increases with each pregnancy.	1	2	3	4	5
21. Taking care of the infants who are born sick or addicted as a result of their mother's drug abuse places unfair burden on the rest of us.	1	2	3	4	5
22. Alcohol is the most often abused drug in the United States.	1	2	3	4	5

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	Strongly Agree	Agree	Not	Disagree	Strongly
23. Drug addicts forget about their babies when they leave the hospital.	1	2	3	4	5
24. Cocaine abusers, unlike alcoholics, rarely recover from their addiction.	1	2	3	4	5
25. Drug and alcohol exposed babies should be given developmental screenings regularly to detect problems early.	1	2	3	4	5
26. Most alcoholics and drug addicts can't stop themselves from abusing even though they know that they will hurt their unborn children.	1	2	3	4	5
27. Society needs to provide care and treatment for affected children.	1	2	3	4	5
28. Recent research indicates that at least 20% of pregnant women use or abuse illegal drugs.	1	2	3	4	5
29. Among young women, cocaine abuse is a bigger problem than alcohol abuse.	1	2	3	4	5
30. Abusing drugs makes people manipulative and unreliable.	1	2	3	4	5
31. Substance abusing women should have their tubes tied.	1	2	3	4	5
32. Alcoholics Anonymous (AA) is an effective treatment for any women with a drug or alcohol problem.	1	2	3	4	5
33. When I see the effects of alcohol and drug abuse on infants, I feel angry at their mothers.	1	2	3	4	5
34. There should be more drug and alcohol treatment available for pregnant women.	1	2	3	4	5
35. Drug and alcohol abuse by women that endangers children is best handled through the legal system.	1	2	3	4	5

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DRUG EFFECTS ON MOTHER

- Prospective Mom
  - Sexual desire
  - menstruation, ovulation
  - pelvic inflammatory disease
- Expectant Mom
  - nutrition
  - medical probs, (eg., anemia, infections)
  - poor prenatal care
  - obstetrical complications

DRUG EFFECTS ON MOTHER

(cont'd)

- Breastfeeding Mom
  - milk production
  - nursing
- Nurturing Parent
  - bonding
  - patience
  - psychological and interpersonal

OBSTETRIC COMPLICATIONS ASSOCIATED WITH DRUG ADDICTION

ABORTION

ABRUPTIO PLACENTAE

AMNIONITIS

BREECH PRESENTATION

OBSTETRIC COMPLICATIONS ASSOCIATED WITH DRUG ADDICTION

(cont'd)

INCREASED NEED FOR CESAREAN SECTION

CHORIOAMNIONITIS

INTRAUTERINE FETAL DEATH

GESTATIONAL DIABETES

OBSTETRIC COMPLICATIONS ASSOCIATED WITH DRUG ADDICTION

(cont'd)

ECLAMPSIA

PLACENTAL INSUFFICIENCY

POSTPARTUM HEMORRHAGE

PREECLAMPSIA

OBSTETRIC COMPLICATIONS ASSOCIATED WITH DRUG ADDICTION

(cont'd)

PREMATURE LABOR

PREMATURE RUPTURE OF THE MEMBRANES

SEPTIC THROMBOPHLEBITIS

DRUG INFORMATION GUIDE

	PHYSICAL SYMPTOMS	LOOK FOR
ALCOHOL (beer, wine, liquor)	Intoxication, slurred speech, unsteady walk, relaxation, relaxed inhibitions, impaired coordination, slowed reflexes	Smell of alcohol on clothes or breath, intoxicated behavior, hangover, glazed eyes
COCAINE (coke, rock, crack, base, whitegirl, snow)	Brief intense euphoria, elevated blood pressure and heart rate, restlessness, excitement, feeling of well-being followed by depression	Glass vials, glass pipe, white crystalline powder, razor blades, syringes, needle marks
MARIJUANA (pot, dope, grass, weed, herb, hash, joint, reefer)	Altered perceptions, red eyes, dry mouth reduced concentration and coordination, euphoria, laughing, hunger	Rolling papers, pipes, dried plant material, odor of burnt hemp rope, roach clips
HALLUCINOGENS (acid, LSD, PCP, MDMA, Ecstacy, psilocybin, mushrooms, peyote)	Altered mood and perceptions, focus on detail, anxiety, panic, nausea, synaesthesia (ex: smell color, see sounds)	Capsules, tablets, "microdots", blotter squares
INHALANTS (gas, aerosols, glue, nitrates, Rush, White Out)	Nausea, dizziness, headaches, lack of coordination and control	Odor of substance on clothing and breath, intoxication, drowsiness, poor muscular
NARCOTICS Heroin (junk, smack, dope, Black Tar, China White); Demerol Dilaudid (D's); Morphine; Codeine	Euphoria, drowsiness, insensitivity to pain, nausea, vomiting, watery eyes, runny nose	Needle marks on arms, needles, syringes. Spoons, pinpoint pupils, cold moist skin

DRUG EFFECTS ON CHILD

- Unborn Embryo/Child
  - death
  - distress
- Newborn
  - premature
  - growth retardation
  - withdrawal
  - physical defects, structural malformation

DRUG EFFECTS ON CHILD

(cont'd)

- Newborn

  - other medical: jaundice, colds, asthma, pneumonia

  - nervous system: sleep, reflexes, response to stimuli, motor development

  - apnea, SIDS

  - risk for HIV infection

  - risk for other STD's

DRUG EFFECTS ON CHILD

(cont'd)

- Nursing Infant

  - toxic reactions to breast milk

  - rapid weight gain from alcohol in milk

  - HIV infection

- Growing Child

  - delayed, abnormal learning & behavioral development

  - delayed, affected emotional development

  - increased susceptibility to illness

  - increased physical and emotional neglect

Identified fetal risks from cocaine include:

1. Hyperactivity of the fetus
2. Abruptio placentae and the onset uterine contractions and labor resulting in an increased risk of prematurity.
3. Intrauterine growth retardation due perhaps to the intermittent impairment of placental blood flow resulting from the vasoconstrictive action of cocaine.
4. Intrauterine cerebral infarctions similar to those experienced by adults.
5. Neonatal neurobehavioral dysfunction.
6. Sudden infant death syndrome.
7. Increased incidence of spontaneous abortion.
8. Necrotizing enterocolitis (decreased blood flow to the GI tract).
9. Postdischarge developmental neurobehavioral disabilities.
10. Visual and auditory dysfunction.

NEONATAL WITHDRAWAL SYMPTOMS

W ■ WAKEFULNESS

I ■ IRRITABILITY

T ■ TREMULOUSNESS, TEMPERATURE VARIATION, TACHYPNEA

H ■ HYPERACTIVITY, HIGH-PITCHED PERSISTENT CRY, HYPERACUSIA, HYPERREFLEXIA, HYPERTONUS

D ■ DIARRHEA, DIAPHORESIS, DISORGANIZED SUCK

R ■ RUB MARKS, RESPIRATORY DISTRESS, RHINORRHEA

A ■ APNEIC ATTACKS, AUTONOMIC DYSFUNCTION

W ■ WEIGHT LOSS, OR FAILURE TO GAIN WEIGHT

A ■ ALKALOSIS (RESPIRATORY)

L ■ LACRIMATION

Cigarette Smoking

Mechanism of Damage

decreased oxygen to the fetus
  vasoconstrictive effect of nicotine causes decreased uteroplacental blood flow

  increased carboxyhemoglobin in the fetus

decreased nutrient flow to the fetus as a result of the decreased uteroplacental blood flow

cigarettes contain 2,000 - 4,000 chemical components that also may damage the developing nervous system

Perinatal insults associated with smoking

reduced birth weights
reduced head circumference
reduced length of gestation
increased neonatal intensive care
altered auditory responsiveness
increased tremors
hypertonicity

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ABNORMALITIES DUE TO PRENATAL ALCOHOL EXPOSURE

Variable features occur from among the following:

Growth: Pre- and postnatal onset growth deficiency.

Performance: Average I.Q. in mildly retarded range. Fine motor dysfunction manifested by weak grasp, poor eye-hand coordination, and/or tremulousness. Irritability in infancy, hyperactivity in childhood.

Craniofacial: Mild to moderated microcephaly, short palpebral fissures, maxillary hypoplasia. Short nose, smooth philtrum with thin and smooth upper lip.

Skeletal: Joint anomalies including abnormal position and/or function, altered palmar crease patterns. Small distal phalanges. Small fifth fingernails.

Cardiac: Heart murmur, frequently disappearing by 1 year of age. Ventricular septal defect most common, followed by auricular septal defect.

Note: The most serious consequence of heavy prenatal alcohol exposure is the problem of brain development and function. Beyond diminished brain cell number and intelligence, there can be problems of malformation, which include heterotopias (faulty migration) of neurons and frank malformation of early brain.

Adapted from: Smith, D.W. (1997) Recognizable Patterns of Human Malformations. WB Saunders Co. pp. 555 & 558.

How to Comfort Your Baby

Behavior	Comforting Techniques	Notes
Irritability	*Handling* For the first few weeks, your baby may need to be swaddled while being held. This warmth and closeness of a tightly wrapped blanket calms the baby. In time, the baby will learn to be calm without help. *Rocking* Slow rocking in an up-and-down motion may help your baby stop crying. The baby may need this kind of help before making face-to-face, eye-to-eye contact with you. *Calming* When your baby becomes calm, hold the baby in a face-to-face position. Look at your baby, and encourage your baby to look at you. Talk to your baby as you play together.	
Restlessness	*Positioning* Place the baby on one side, with a rolled-up blanket supporting the baby's spine. Place rolled-up cloth diapers between the baby's legs. Let the baby's legs bend a little. This will help the baby to move the legs freely, and the baby will be less stiff. Change your baby's position often - every half-hour, if needed. *Bathing* Bathe your baby every day. Use warm water and a mild soap such as Neutrogena or Dove. Dry your baby well, and don't use too much lotion or baby oil. Apply medicines , ointments, or creams that your doctor has prescribed or recommended.	
Poor Feeding	*Feeding* Feed your baby small amounts of formula every three hours. Later, when the baby is stronger, you can give more formula. The time can be lengthened by a few minutes until it is four hours between feedings. For the first four months, give your baby nothing but formula. Do not switch from formula to whole milk until the baby is one year old. Be sure to gently and slowly burp the baby after every feeding. *Burping* If the baby has been crying for more than a few minutes before feeding, take time to calm the baby. Place the baby against your chest, and gently pat the baby's back to release excess air caused by crying. Feed the baby three or four ounces of formula. Then burp the baby. Burping can be done while holding the baby in a sitting position with one hand on the baby's stomach and the other hand gently rubbing and patting the baby's neck.	

Reprinted with permission from: Puttkammer, C. (1994). Working with Substance Exposed Children. Arizona: Therapy Skills Builders.

Behavior	Comforting Techniques	Notes
Crying	*Baby is not able to sleep* Reduce the stimulation around the baby. Turn down the lights, reduce noises or music. Pat your baby on the back, and talk to the baby in a soft humming voice. *Pacifier* When the baby has been fed and still tries to suck the fists or the clothes, a pacifier may help the baby to relax.	
Breathing Problems	*Sneezing, runny nose* If mucous or formula is in the nose, clean the baby's nose with a bulb syringe. *Trouble breathing* If your baby is uncomfortable lying on the stomach after feeding and burping, place the baby on one side. Roll up a blanket and place it against the baby's back for support. When your baby is awake, active, and alert, let the baby sit up in an infant seat. If the baby's color is pale or appears blue, call 911 immediately.	
Play positions	Place your baby on the stomach to play. Put colorful, stimulating toys beside the baby. This will encourage the baby to turn from the waist and reach for the toys.	
Carrying	Carry your baby facing forward, supported by your arm under the baby's thighs. In this position, the baby's arms can be kept forward. This makes it easier for the baby to bring the hands together. This position also helps the baby strengthen the muscles needed for reaching and grasping.	
Handling	Drug-exposed babies are sensitive to quick, rough movements. They may respond by stiffening their bodies or crying. Slow, gentle swinging is better for these babies. Watch to see how your baby reacts to being handled. The baby will look distressed when the handling is too rough or uncomfortable.	
Exercise	Your baby's muscle development needs to be evaluated when the baby is four months old. If any problems are discovered at that time, the doctor will recommend a physical therapist or occupational therapist. These specialists can start an exercise routine to help your baby overcome any problems. Some babies are given exercise routines even before they come home from the hospital. If you have been given an exercise routine for your baby, follow the schedule strictly. The exercises will help your baby loosen up and prepare for active movement.	

Reprinted with permission from: Puttkammer, C. (1994). Working with Substance Exposed Children. Arizona: Therapy Skills Builders.

Case Study

Do a genogram from the following information; note familial background of substance abuse.

Ms. J. comes from a family of 5 children, 2 boys and 3 girls. Although the children are grown, her mother and father are involved in their daily lives. The maternal grandmother lives in the family home. Each family member has had substance abuse problems at some time in their lives. Presently, 1 boy and 2 of the girls, including Ms. J., are using drugs.

Ms. J. has 3 children, the youngest is the 4 month old baby in our program. The oldest child's father was not a substance abuser, but the father of the 2 youngest children uses and at times has been a dealer. Ms. J. and her present partner and their 3 children live in the family home.

Case Study

Where does the PSS start? Identify important issues for beginning the intervention.

On January 5, 1997 the PSS was assigned a new mother who has been identified as a drug user. Ms. Smith is a 31 year old mother of 5 children. The fifth child is the infant boy that was experiencing withdrawal symptoms. The paper work stated that Ms. Smith seemed depressed. Ms Smith had indicated that she wanted to place the baby for adoption, but recanted that after her baby was born. Her stay in the hospital was 5 days due to complications. The baby remained in the hospital for an extra 3 days during which Ms. Smith did not visit. Ms Smith was late picking up the baby to take him home. She says this was due to transportation problems.

Ms. Smith is currently living with the baby's father's sister in a section 8 apartment complex. Ms. Smith has been in 3 drug treatment facilities and is currently receiving methadone for her dependency.

Case Study

What are the potential problems in this situation? How can we positively impact this situation?

The greatest increase in AIDS is in young women who use drugs or are partners of IV drug users. Ms. Jones has been diagnosed with AIDS. She sees herself as in the process of dying and wants to try to have a healthy baby to leave a legacy.

Case Study

Identify important factors and responses in order to continue empowering this mom.

This PSS has been working with Ms. Smith for 2 months. She has been complying with home visits and having her son ready for the visit. At the last visit, she told the PSS that she was bored being at home.

The PSS called to verify their meeting time for her first visit of the third month of the program. Ms. Smith was very hesitant about her regular appointment. She indicated that she wanted to change the date and time. The PSS agreed. The PSS went for the home visit at the new time but Ms. Smith had moved. The next day, CPS called to speak with the PSS about the status of this mother in our program. Ms. Smith had given CPS the program's name as her drug treatment program.

Case Study

What's a PSS to do? How would you approach this situation?

After a 3 month absence from the program, Ms. Smith called her PSS. She stated that she was in need of food for her baby. She also had no place to live. All her children, except for the baby, had been placed in temporary custody with other family members. She has been clean for 5 days and she did this on her own. She wants to stay clean for her baby. She needs her children back. She wants to be a good parent to her children.

ROLE PLAY FEEDBACK

WHAT DO YOU THINK YOU THE PARENTING SUPPORT SPECIALIST DID WELL?

WHAT COULD THE PARENTING SUPPORT SPECIALIST HAVE CHANGED OR DONE DIFFERENTLY?

WHAT OTHER THINGS DO YOU THINK THE PARENTING SUPPORT SPECIALIST MIGHT SAY OR DO TO HELP A MOTHER IN THIS SITUATION?

Adapted with permission from
Resource Mothers, 1993.

SUBSTANCE ABUSE

Post-Unit Test

1. Describe one change in your attitude about drug abuse in pregnancy.
2. Describe 3 risks of substance abuse to pregnant women.
3. Describe 3 risks of substance abuse to post-partum women.
4. Identify 3 possible effects of intrauterine drug exposure on the newborn.
5. List 5 symptoms of neonatal drug withdrawal.
6. If you are with a mom whose baby seems inconsolable, what could you suggest that the mother do?
7. Describe important factors in the "Cycle of Addiction".
8. What would you do to begin intervention with a mom identified as a substance abuser?
9. If you are feeling frustrated while working with a mom who is abusing substances, what might be contributing to this feeling?
10. Describe one long term effect of each of the following drugs on the growth and development of prenatally exposed children.

    Cocaine

    Heroin

    Marijuana

    Alcohol

    Smoking

    Prescription drugs

POST-UNIT EVALUATION
UNIT COVERED: _____

DATE_______________

1. Do you feel we covered all the information in this unit that we said we were going to?

2. What did you like best about the unit?

3. What did you like least about the unit?

4. Was the information in this unit presented clearly? _____ If not, please explain.

Adapted with permission from Resource Mothers, 1993.

5. In which skill areas do you feel you need more practice or help?

6. How can we make this unit better?

7. Any additional comments?

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Unit 25
EVALUATION AND CLOSING CEREMONY

Finally! The day has come for graduation! This is a time for celebration! It is a time to feel good about the successful completion of a wonderful training. It is also a time to look forward! Parenting Support Specialists will be leaving the "safe" environment of the classroom to meet the challenges that lie ahead.

Objectives

By the end of this session, participants will have:

- Articulated their thoughts about the training.
- Identified areas of growth as well as areas of continued learning need.
- Completed the post-test questionnaire (optional).
- Completed the post-training evaluation (optional).
- Received their course certificate in a closing or graduation ceremony.

Time

2 hours (or longer if you have a luncheon or other festivity)

Outline

A. Written Evaluations (optional)
B. Wrap-Up: Review and Discussion
C. Closing or Graduation Ceremony

Materials

- Post-Training Evaluation (optional **Handout #1**)
- Post-Test Questionnaire (optional **Handout #2**)
- Certificate of Participation (see **Training Aid #1** as sample)
- Easel, newsprint, markers, and tape or blackboard and chalk

Advance Preparation:

- Make sufficient copies of the post-test and post-training evaluation (optional). See **Handouts #1 and #2** and adapt or rewrite them, as appropriate.
- Review the entire agenda of the training program, and be prepared to elicit comments, suggestions, and critiques from participants.
- Ask trainees to select one representative of this training class to serve as your co-facilitator during the training wrap-up. This co-facilitator may want to write a poem, or share a few thoughts with the group about the training. The co-facilitator will help you design this wrap-up session in the most relevant way to meet the needs of the PSS trainees.
- Meet with this representative before the session to prepare an agenda of topics you plan to discuss, questions you wish to ask, methods of reflection, etc.

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- Plan whom you are going to invite to speak at the closing ceremony (if anyone). Issue invitations. Be sure the Program Team (Program Director, Supervisor and other staff) are included.
- Ask trainees if they wish to prepare a musical presentation or other inspirational piece to share with the group. Or, invite a local performing group to provide a musical or other culturally relevant presentation to the group.
- Prepare certificates for participants.
- Arrange for refreshments, or ask participants to share in a pot-luck.
- Contact the local media.

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Resource Mothers, 1993.

A. WRITTEN EVALUATIONS (30 minutes) (optional)

Rationale: It is best to ask participants to complete all written work before discussing any aspect of the program. This should yield more accurate information, as trainees will be completing forms on both process and content – based on what they believe and what they know – **before** they hear what any of their peers have to say.

Procedure: 1. Explain that in order to provide the best possible training to future PSS trainees, it is important that all participants have an opportunity to express their opinions on current training and make suggestions for possible improvements in subsequent programs. Emphasize that one learns from constructive criticism and that in order to improve the training, you (as well as the PIP program staff) need their thoughts and suggestions.

2. Distribute copies of **Handout #1**, the Post-Training Evaluation, to participants and allow them to complete it. In order to elicit candid and frank comments, tell them that writing their name on the questionnaire is **optional**.

3. As soon as all **Handout #1's** have been completed and collected, distribute **Handout #2**, the Post-Test, or whatever Pre/Post-Test your program developed. This should look familiar to trainees, as many of the questions will be similar to ones already asked of them at the start of this training. They should not discuss their answers with any of the colleagues as they are completing the questionnaire. As participants finish, collect these questionnaires.

4. Be sure everyone has turned in both questionnaires before beginning the wrap-up.

B. WRAP-UP: REVIEW AND DISCUSSION (1 hour)

Procedure: 1. This hour is reserved for a critical reflection of the whole training workshop. You should begin by asking trainees to share their thoughts on what has happened. Perhaps refer back to the River of Life exercise. How have things progressed? Where do they feel they are now? What needs do they have? What goals have they set, and what goals have been met? What can you (the trainer or the program Supervisor) do to help the PSS further meet her goals? You may want to reflect back on the Training Objectives you prepared for Unit 1. Have the objectives been met?

2. Solicit participants' comments, write down their comments on the chalk board or flipchart, and encourage discussion.

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3. Follow whatever agenda or format you and your co-facilitator have agreed upon. Make a point of involving all participants in a discussion of the overall training and how it might be improved. Find out with which skills and on what topics they now feel thoroughly familiar, and in what areas they feel the need for future training. This is a good time to emphasize the importance of in-service training. Explain that all topics they agree need further explanation can be addressed in an in-service session.

4. Make notes on participants' comments for future use and to share with program staff.

5. Point out that new skills will be strengthened as they are used. Encourage the use of the verbal and non-verbal communication skills they practiced during all the exercises and role plays. Encourage trainees to continue to support each other. Learning never ends! Everyone still has much to share and much to learn – it is a life-long process!

6. Mention that much of the training has been spent discussing various ways trainees – once they are PSS's and have a case load – will be able to help their clients. Ask someone in the group to comment on what being a PSS may mean for their lives. Elicit comments from others, until everyone who wants to has contributed.

7. If you have video-taped several of the practice sessions, participants often enjoy viewing a few early role plays, followed by some performed towards the end of the training. Select ones where the improvements are apparent.

8. Before concluding this session, ask whether there are any other comments anyone wishes to make, or any remaining questions regarding the training or possible follow-up.

C. CLOSING OR GRADUATION CEREMONY (30 minutes)

Rationale: It is important to celebrate all the hard work that has been accomplished over the course of the training. This is a milestone – PSS's are now ready assume a new career.

Procedure: 1. Welcome any invited guests, such as representatives of your agency and other collaborating institutions, family and friends of the new PSS' and any invited speaker(s).

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2. Proceed with whatever program you have planned for this gala occasion. In addition to the formal activities, participants may wish to perform or do skits about their work/community.

3. At the close of the ceremony, ask the Program Director to distribute a personalized certificate or diploma to each participant (Note that **Training Aid #1** is a sample certificate that can be modified for your particular program).

4. Serve refreshments. Congratulations!

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POST-TRAINING EVALUATION

1. Below is the list of the different sessions (units) in this workshop. Please circle on a scale of 1 to 5 how useful each session was to you.

1 – Least Useful 5 – Most Useful

1.	Introduction to Training Workshop	1	2	3	4	5
2.	Communication and Relationship Building	1	2	3	4	5
3.	Coping with Stress: Problem Solving & Decision Making	1	2	3	4	5
4.	Building Self-Esteem/Dealing with Feelings	1	2	3	4	5
5.	How to Use Support Materials	1	2	3	4	5
6.	Working with Families	1	2	3	4	5
7.	Cultural Diversity	1	2	3	4	5
8.	Postpartum Care and Planning	1	2	3	4	5
9.	Family Planning	1	2	3	4	5
10.	Infant Care and Nutrition	1	2	3	4	5
11.	Health Care in First Year	1	2	3	4	5
12.	Child Growth and Development	1	2	3	4	5
13.	Identifying Family Needs and Accessing	1	2	3	4	5
	Community Resources	1	2	3	4	5
14.	Managing and Maintaining Home Visits	1	2	3	4	5
15.	Evaluation and Closing Ceremony	1	2	3	4	5
16.	Child Growth and Development Birth to 1 Month	1	2	3	4	5
17.	Child Growth and Development 1 to 4 Months	1	2	3	4	5
18.	Child Growth and Development 4 to 8 Months	1	2	3	4	5
19.	Child Growth and Development 8 to 12 Months	1	2	3	4	5
20.	Child Growth and Development 1 to 2 Years	1	2	3	4	5
21.	Children in Violent Circumstances	1	2	3	4	5
22.	Behavior and Discipline	1	2	3	4	5
23.	Health Promotion for Families	1	2	3	4	5
24.	Personal Safety	1	2	3	4	5

2. What did you like most about the training workshop?

Why?

3. What did you like least about the training workshop?

Why?

4. Overall, how valuable was the training workshop for you? (Check the box that best describes your feelings.)

☐ Very valuable ☐ Valuable ☐ Of moderate value ☐ Of little value ☐ Of no value

Adapted with permission from
Resource Mothers, 1993.

5. Do you feel we covered all the information in this training that we said we were going to?

6. Was the information in this training program presented clearly?

   ☐ Yes ☐ No

   If not, please explain.

7. In which skill areas do you feel you need more practice or help?

8. How could we make this training program better?

9. Additional comments?

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POST-TEST QUESTIONNAIRE

1. What is the goal of the Pride in Parenting project?

2. Name four qualities or characteristics of an effective Parenting Support Specialist.
    1.
    2.
    3.
    4.

3. List three advantages of going into a mother's home to provide information and support.
    1.
    2.
    3.

4. List three characteristics of active listening.
    1.
    2.
    3.

5. Name five traits found in healthy families.
    1.
    2.
    3.
    4.
    5.

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6. Describe the difference between discipline and punishment.

___

___

___

7. List two ways a woman can protect herself from getting an STD.

1. ___

2. ___

8. List three characteristics of the high violence/abusive parent.

1. ___

2. ___

3. ___

9. List three myths about ethnicity and cultural diversity that are prevalent in our society.

1. ___

2. ___

3. ___

10. At what age do you think baby's first begin to:

Smile___
Fill and dump toys___
Sit up___

Walk___
Play peek-a-boo___
Say words___

11. List three tasks or activities that you as a Parenting Support Specialist may be asked to performs.

1. ___

2. ___

3. ___

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12. What do you tell your client who tells you she doesn't want anymore children but she stopped taking birth control pills because they made her feel sick?

____

____

____

13. Can you spoil a two to three month old baby? Why or why not?

____

____

____

14. Is it important that children get all immunizations? Yes___ No___ Maybe___ Why?

____

____

____

15. Discuss two positive and two negative ways of dealing with anger.
POSITIVE:

1. ____

____

2. ____

____

NEGATIVE:

1. ____

____

2. ____

____

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16. List three warning signs in the postpartum period.

    1.

    2.

    3.

17. Name five social services agencies used frequently by families in need and how referrals are made.

    1.

    2.

    3.

    4.

    5.

18. You make a weekly visit to one of the mothers. She tells you her baby has been crying all morning. How would you respond. Be specific.

19. List three ways you can ensure your safety on home visits.

    1.

    2.

    3.

20. Name four things mothers can do to stay healthy.

    1.

    2.

    3.

    4.

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UNIVERSITY OF THE DISTRICT OF COLUMBIA DIVISION OF CONTINUING EDUCATION

Certificate of Completion

CERTIFICATE OF PARTICIPATION

this is to certify that ______________

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Date

Instructor ______________ **Program Director** ______________ **Division Director** ______________